Health Care Regulation Committee

Wednesday, March 22, 2006
9:00 AM - 12:00 PM
212 Knott Building

Allan G. Bense
Speaker

Rene Garcia
Chair

House of Representatives

Committee on Health Care Regulation

AGENDA

March 22, 2006
9:00 AM - 12:00 PM
212 Knott Building

I. Opening Remarks by Chair Garcia

II. Consideration of the following bills:

HB 427 – Surgical First Assistance by Rep. Homan

HB 611 – Patient Records by Rep. Bucher

HB 805 CS – Policies, Contracts, and Programs for the Provision of Health Care Services by Rep. Benson

HB 1093 – Physicians by Rep. Altman

HB 1157 – Dental Charting by Rep. Mayfield

HB 1293 – Medical Malpractice Insurance by Rep. Grant

HB 1409 – Florida Health Information Network, Inc. by Rep. Benson

HB 1411 – Public Records by Rep. Benson

III. Closing Remarks

IV. Adjournment

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 427 Surgical First Assistance
SPONSOR(S): Homan and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1044

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee		Hamrick	Mitchell
2) Insurance Committee			
3) Health Care Appropriations Committee			
4) Health & Families Council			
5)			

SUMMARY ANALYSIS

HB 427 establishes the licensure of certified surgical first assistants. A surgical assistant works under the direct supervision of a surgeon and provides technical functions that help a surgeon perform an operation. The bill creates a regulatory scheme, provides definitions, scope of practice, employment guidelines, continuing education, accountability, and rules and guidelines. The licensure is voluntary. Section 11.62, F.S., the Sunrise Act that establishes criteria for new regulation of professions, states that it is the intent of the Legislature that no profession or occupation be subject to regulation by the state unless the regulation is necessary to protect the public health, safety, or welfare from significant and discernible harm or damage; and no profession or occupation be regulated by the state in a manner that unnecessarily restricts entry into the practice of the profession or occupation. The Sunrise Act requires proponents of regulation to provide information to the Legislature that establishes the need and effects of regulation. The proponent for the regulation that submitted this information is the Florida Association of Surgical Assistants (FASA). The bill provides for regulation of approximately 432 certified practitioners, which currently perform the duties of a surgical first assistant.

According to the Department of Health, hospitals are largely responsible for providing oversight and setting standards for the performance of surgical assistants in Florida. Proponents for licensure of certified surgical first assistants have not provided sufficient documentation, based on the evaluation criteria established in s. 11.62, F.S., to warrant the establishment of a new profession at this time. They stated, "we know of no documented harm to the public" and "no instances of consumer injury were found."

Currently, surgeons have been unable to bill for the services of a surgical assistant unless the assistant was licensed as a physician assistant or nurse. The bill amends s. 627.419(6), F.S., Part II of the Florida Insurance Code, to allow for direct reimbursement of a certified first assistant.

Fiscal Impact: Currently, these services are covered by global payments made by health insurance plans to hospitals and surgeons. Any increased payments required by this bill will have the effect of increasing the cost of health care. According to the Department of Health, this profession is expected to operate in a deficit and the allocated expenses for administrative, complaint, investigative, and prosecution services range from $19,000 and $243,000 or more annually in addition to the direct expenses for licensure.

The bill will take effect on July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provides limited government-The bill increases regulation of hospital surgical practices and provides for the creation of a regulatory scheme for a new profession.

B. EFFECT OF PROPOSED CHANGES:

HB 427 provides for the regulation of certified surgical first assistants. A surgical assistant works under the direct supervision of a surgeon and provides aid in operative technical functions that help a surgeon perform a safe operation. A wide range of health professionals function as surgical assistants, such as physician assistants, nurses, and surgical technologists.

The bill does not establish mandatory licensure. The bill provides that a certified surgical first assistant license is not required of a registered nurse, an advanced registered nurse practitioner, a registered nurse first assistant, or a physician assistant as a condition of employment. The bill creates a regulatory scheme, provides definitions, scope of practice, employment guidelines, continuing education, accountability, rules and guidelines and proposes licensure. According to the proponents, the bill creates a system of monitoring to safeguard the consumer. The bill provides for regulation of an estimated 432 certified practitioners, who currently perform the duties of a surgical first assistant.

The bill provides for the regulation of a new profession, certified surgical first assistants. According to s. 11.62, F.S., the Sunrise Act, it is the intent of the Legislature that:

- No profession or occupation be subject to regulation by the state unless the regulation is necessary to protect the public health, safety, or welfare from significant and discernible harm or damage and that the police power of the state be exercised only to the extent necessary for that purpose; and

- No profession or occupation be regulated by the state in a manner that unnecessarily restricts entry into the practice of the profession or occupation or adversely affects the availability of the professional or occupational services to the public.

In determining whether to regulate a profession or occupation, s. 11.62, F.S., requires the Legislature to consider the following:

I. Whether the unregulated practice of the profession or occupation will substantially harm or endanger the public health, safety, or welfare, and whether the potential for harm is recognizable and not remote;
II. Whether the practice of the profession or occupation requires specialized skill or training, and whether that skill or training is readily measurable or quantifiable so that examination or training requirements would reasonably assure initial and continuing professional or occupational ability;
III. Whether the regulation will have an unreasonable effect on job creation or job retention in the state or will place unreasonable restrictions on the ability of individuals who seek to practice or who are practicing a given profession or occupation to find employment;
IV. Whether the public is or can be effectively protected by other means; and
V. Whether the overall cost-effectiveness and economic impact of the proposed regulation, including the indirect costs to consumers, will be favorable.

Section 11.62, F.S., requires the proponents of regulation to submit information, which is structured as a sunrise questionnaire to document that regulation meets these criteria. The effects section of the bill analysis is structured to address these five criteria. A sunrise questionnaire was submitted to staff by the proponents of the legislation to assist the Legislature in determining the need for regulation of

certified surgical first assistants and analyzing the proposed legislation seeking to establish regulation under the Department of Health. The proponent for the regulation and entity responsible for submitting the sunrise questionnaire is the Florida Association of Surgical Assistants (FASA). FASA represents the certified surgical first assistants and during their 2005 annual business meeting, the Board of Directors responded to the requests of its members by selecting a core group of nine practitioners to represent them in this endeavor.

CRITERIA FOR THE PROPOSED PROFESSIONAL REGULATION

I. Substantial Harm or Endangerment

According to the information provided to staff in response to the sunrise questionnaire, there is an external and internal need for a regulatory standard for these reasons:

- There is an inherent risk of physical harm in surgery and a wide range of health care professionals, with varying educational and professional experience who perform as a surgical first assistant.
- The lack of a standard of practice places an undue burden and responsibility on hospitals to determine whether or not a practitioner will be allowed to practice in a given hospital.
- The lack of a regulatory body to ensure that only the most qualified individuals are involved in the practice of surgical first assisting, places a great risk on the general public.
- The lack of any recordkeeping by a centralized regulatory agency endangers the public health in as much as there is no way for a patient to ensure that the particular individual performing as a surgical first assistant is qualified to assist in surgery and that they do not have a history of malpractice in the profession.
- There is a demand from certified surgical assistants to ensure that only qualified individuals are allowed to practice.

However, based on the response provided by the proponents of this legislation, "*we know of no documented harm to the public*" and "*no instances of consumer injury were found.*" The proponents for regulation were not able to provide estimated numbers of complaints against professionals practicing in this profession. The bill does not require licensure and does not provide any new protections for patient safety, therefore does not meet the safety criteria for licensure.

II. Specialized Skill or Training, and Measurability

According to the information provided in the sunrise questionnaire, the practice of the profession requires specialized training and may require practitioners to handle or operate electrosurgical instruments, endoscopic or laproscopic instrumentation, laser equipment or gas beam coagulation equipment as well as other technology. Surgical assistants are required to use sophisticated equipment as well as other technology, which require highly specialized knowledge and skill that is acquired through education and experience.

Proponents of the legislation claim that surgeons depend on certified surgical first assistants to perform skills, offer input and insight based on his/her knowledge of a procedure or equipment used, for the task at hand. The proponents also state "there is no consensus of competency in Florida, and that is why the bill proposes to create guidelines through licensure." According to the questionnaire, "competent practice can be measured and currently the surgeons and the credentialing body at the hospital perform practitioner peer review. The burden is placed on the hospital and the employer to grade competency."

Surgical first assistants work under the direct supervision of the surgeon and may be asked to assist in a wide variety of devices in many multi-specialties. The surgeon is always present, but according to the proponents of the legislation, the judgment and the skill of the assistant plays a large part in the success of a surgery.

However, based on a study conducted by the Government Accountability Office (GAO)[1], "*there is no widely accepted set of uniform requirements for experience and education* that the health professionals who serve as assistants-at-surgery [or surgical assistants] are required to meet." "GAO found that there was insufficient information about the quality of care provided by assistants-at-surgery [or surgical assistants] generally, or by a specific type of health professional, to access the adequacy of the requirements for members of a particular profession to perform the role." According to the questionnaire, currently, first assistants must provide documented experience and submit to a written test that serves to document the knowledge, skills and abilities they possess. Each of the national credentialing agencies sets their own criteria requirements and examination.

It is not clear that only one licensed profession should perform the duties of a certified surgical first assistant. The educational requirements required of a surgical assistant seeking certification by any of the three accreditation credentialing bodies identified in the bill are varied.

III. Unreasonable Effect on Job Creation or Job Retention

According to the sunrise questionnaire, "hospitals set their own policy and procedures regarding who can perform as a surgical assistant. Certified Surgical Technologists, non-certified surgical technologists, along with other non-certified assistive personnel, may be employed by hospitals and out-patient surgery centers throughout the state. It would be impossible to estimate how many individuals this encompasses. Best estimate would be over 1700."

The proponents of the regulation state that registered nurse first assistants and physician assistants provide the same service in the operating room as a certified surgical first assistant, but have a larger scope of practice that may involve the assessment of the patient before and after surgery. Certified surgical first assistants are trained specifically to assist the surgeon in the operating room.

Since the bill does not require licensure, there may not be an unreasonable effect on job creation or retention.

IV. Can the Public be Effectively Protected by Other Means?

The proponents for the regulation claim that the existing protections available to consumers are insufficient, and that the burden of protecting the public lies on hospitals and professional organizations. They contend that there are other means to protect the public, but they are not being utilized to oversee the duties of surgical first assistants. These other means are: code of ethics; codes of practice enforced by professional associations; dispute-resolution mechanisms such as mediation or arbitration; recourse to current applicable law; regulation of those who employ or supervise practitioners; caveat empor, i.e., "let the buyer be beware"; and supervision that is the burden of the employer and/or facility. Proponent's state that volunteer certification as it currently exists, is good, but does not offer all the safety nets that government intervention provides in the form of licensure.

It appears that the alternatives to professional licensure, currently utilized, are effective. Because hospitals currently oversee safety in surgery and surgeons are responsible for the practice of their surgical assistants, and no instances of harm have been documented.

[1] United States General Accounting Office, Report to Congressional Committees. January 2004. Medicare: Payment Changes are Needed for Assistants-at-Surgery. GAO 04-97.

V. Favorable Cost-effectiveness and Economic Impact

According to the sunrise questionnaire, approximately half a million people undergo surgery annually in Florida. "The regulation of this profession will not affect this estimate." Proponents estimate that the cost to insurance companies will increase, but that policyholders have already paid for the services. Insurance companies will be expected to pay for provided services, such as, the services provided by a surgical first assistant. The proponents of the bill project that half of the estimated 432 certified professionals will seek licensure in Florida and another 100-150 applicants will apply annually.

The bill provides for the regulation of the profession by an existing board, requires credentialing and licensure, licensure renewal, enforcement for noncompliance to regulatory guidelines.

See the "Fiscal Impact on State Government" for the Department of Health's projections on the fiscal impact.

BACKGROUND INFORMATION

Legislative History

The occupational group seeking regulation is the Certified Surgical First Assistants. To date, there is no history of regulation or attempts at regulating this profession in Florida.

Who is a Certified Surgical First Assistant?

A wide range of health professionals function as surgical assistants. Surgical assistants may be referred to as first assistants or assistants-at-surgery. Examples of such health professionals that function as surgical assistants are:

- Physicians (post-residency)
- Physicians in residency
- Registered nurses, including those in surgical specialties, such as orthopedics
- Licensed practical nurses
- Nurse practitioners
- Clinical nurse specialists
- Certified registered nurse assistants
- Surgical technologists
- Physician Assistants
- Ophthalmic assistant/technicians
- Surgical assistants
- Orthopedic technologists
- Orthopedic physician assistants
- International medical graduates

Profile of the Profession

According to information provided in the sunrise questionnaire, the American College of Surgeons defines "*surgical assistants*" as those who provide aid in exposure, hemostasis, closure and other operative technical functions that help the surgeon carry out a safe operation with optimal results. Some of the specific tasks include: making initial incisions (opening), exposing the surgical site (retracting), stemming blood flow (hemostasis), reconnecting tissue (suturing) and completing the operation be reconnecting external tissue (closing). Additionally, surgical assistants should possess knowledge of sterility requirements, aseptic techniques, draping procedures, operating room equipment, drain placement and cauterization, and dressing techniques.

Scope of Practice as Defined in the Bill

The bill provides a scope of practice for a certified surgical first assistant which is limited to surgical assisting and tasks that are delegated by the supervising physician. A definition of "surgical assisting" is provided that means providing aid under the direct supervision in exposure, hemostasis, closures, and other intraoperative technical functions that assist a physician in performing a safe operation with optimal results for the patient. The bill also provides that the duties of a certified surgical first assistant are limited to the scope of the certification in surgical assisting functions while under the direct supervision of a physician. However, the bill does not provide a definition or explanation for the "scope of certification." The bill stipulates that a certified surgical first assistant may only work in a medical clinic, hospital, ambulatory surgical center, or similar medical institution.

The bill specifies that the physician supervising a certified surgical first assistant shall be qualified in the medical areas in which the certified assistant is to perform and may be responsible and liable for the performance and acts and omissions of the assistant.

Certification Bodies and the Requirements for Certification

Currently there is a wide range of non-physician allied health professionals trained as surgical assistants or technologists in a variety of programs. According to the Department of Labor, most employers prefer to hire surgical assistants or technologists who are certified. Surgical assistants or technologists may obtain voluntary professional certification by graduating from an accredited program and passing a national certification examination. To qualify to take the exam, candidates follow one of three paths: complete an accredited training program, undergo a 2-year hospital on-the-job training program, or acquire seven years of experience working in the field.

The bill requires certified surgical first assistants to be certified by one of the following three professional organizations:

- The American Board of Surgical Assistants (ABSA), founded in 1987, administers a national certification examination for surgical assistants. This body provides for surgical assistant-certified or (SA-C) certification title. Their examination covers all surgical disciplines and areas of preoperative medicine. It evaluates knowledge of surgical anatomy, procedures and techniques, diagnostic studies, emergencies, OSHA regulations and general patient safety.

- The National Surgical Assistant Association (NSAA), which began in Virginia in 1979. This body provides for certified surgical assistant (CSA) certification title. The National Surgical Assistant Association established practice standards and develop a certification examination with the help of the Department of Surgery at Norfolk General Hospital.

- The Liaison Council on Certification for the Surgical Technologist (LCC-ST), was established in 1974 as the certifying agency for surgical technologists. This body provides for certified first assistant (CFA) certification title. The Council determines the eligibility for the granting and revocation of certification of surgical technologists and first assistants.

Current Statutory Prohibition for Unlicensed Activity in Surgery unless Authorized and Pass a Competency Assessment

Section 395.0197(1)(b) 3., F.S., prohibits unlicensed persons from assisting or participating in any surgical procedure unless the facility has authorized the person to do so following a competency assessment. Assistance or participation must be done under the direct and immediate supervision of a licensed physician and must not be an activity that may only be performed by a licensed health care practitioner.

Education and Regulation in Other States

According to a study conducted by the U.S. General Accounting Office (GAO),[2] there is no widely accepted set of uniform requirements for experience and education that the health professionals who serve as assistance-at-surgery or surgical first assistants are required to meet. The health professionals whose members provide assistants-at-surgery services have varying educational requirements. No state licenses all the health professionals who serve as assistants-at-surgery, and the health professional licenses that states do issue typically attest to the completion of broad-based health care education, rather than education or experience as an assistant. Furthermore, the certification programs developed by the various non-physician health professional groups whose members assist at surgery differ. The GAO found that there was insufficient information about the quality of care provided by assistants-at-surgery generally, or by a specific type of health professional, to assess the adequacy of the requirements for members of a particular profession to perform the role.

Based on the findings in the GAO study, in January 2004 only one state, Texas, had a specific assistant-at-surgery license. Even though Texas licenses assistants-at-surgery, a license is not required to serve as an assistant-at-surgery. According to the proponents of the bill two additional states now regulate surgical first assistants: Kentucky and Illinois.

Surgical Education, Experience Requirements, and Licensure Requirements for Surgical First Assistants

Health Profession	General Education Requirements	Licensure Requirements In All States	Example of Surgical Experience Requirements
Physician			
Physicians (post-residency)	Doctor of medicine or osteopathy	Yes	
Physician in residency	Doctor of medicine or osteopathy	Yes	
Nurse			
Registered nurse, including surgical specialties * (*A variety of surgery-related certifications are available for nurses. Some of these are for surgical specialties. Orthopedic nurse certified requires 1,000 hours of experience as an orthopedic nurse. Certified plastic surgical nursing requires 2 years experience in plastic surgery. Both certifications include operating room experience, but neither requires OR experience.)	Associate's or bachelor's degree in nursing or non-degree hospital diploma	Yes	Requirements vary by certification program, but surgical experience is not required for certain surgical-related certifications
Nurse practitioner	Master's of science in nursing or non-degree certificate	Yes	
Clinical nurse specialist	Master's of science in nursing	Yes	
Certified registered nurse first assistant	Bachelor's degree and certification program with 2-3 surgical classes	Yes	2,400 hours of operating room experience in the scrub or circulating role and 2,000 hours as assistant-at-surgery
Licensed practical nurse	1-year program	Yes	

[2] United States General Accounting Office, Report to Congressional Committees. January 2004. Medicare: Payment Changes are Needed for Assistants-at-Surgery. GAO 04-97.

Other health professions			
Surgical technologist	Associate's degree, military or non-degree certificate	No	2 years of surgical experience
Physician assistant	Associate's or bachelor's degree or non-degree certificate	Yes	
Ophthalmic assistant/technician	Certificate programs or work experience	No	18 months of surgical experience
Surgical assistant	Bachelor's degree or non-degree certificate	No	2-3 years of surgical assistant experience, depending upon certification program
Orthopedic physician assistant	Associate's degree, military or non-degree certificate, or 5 years of experience	No	1 year surgical experience
International medical graduate	Non-U.S. degree in medicine	No	

Source: 2004 GAO Report Medicare Payments for Assistants-at-Surgery

Medicare Reimbursement of Surgical Assistants

A goal of Medicare is to ensure that payments to providers are for the appropriate amount and only for medically necessary services.[3]

According to the GAO report on Medicare costs,[4] surgical assistants have a wide range of educational training and expertise, and different levels of professional requirements that do not justify the same level of reimbursement by Medicare.

Depending on the procedure performed, and the qualifications and training of the provider assisting in surgery, the services may be separately billable to Medicare. Medicare reimburses only licensed personnel as assistants-at-surgery and does not reimburse for surgical assistants such as registered nurse first assistants, orthopedic physician assistants, licensed practical nurses, certified surgical technologists, or other licensed or non-licensed personnel. The hospital or surgeon typically pays these practitioners.

When Medicare reimburses for an assistant-at-surgery, the reimbursement rate is not at the full level received by a physician. The reimbursement rate depends on the level of education and training of the assistant. Physicians are paid 16 percent of the physician fee for surgery; physician assistants, clinical nurse specialists and nurse practitioners are paid 85 percent of 16 percent (or 13.6 percent) of the physician fee.

Impact of the Bill on New Insurance Policies and Current Statutory Provisions for Reimbursement

The bill amends s. 627.419(6), F.S., Part II of the Florida Insurance Code relating to the construction of insurance policies, requiring that, if a policy pays for services provided by surgical first assisting benefits, then the policy is construed to make payments to certified surgical first assistants or their employers. The bill applies to individual and group health insurance policies, except for small group basic and standard policies. The bill does not require an insurer to directly reimburse a certified first assistant if the assistant is paid or will be paid for their services by a health care facility. Currently, these services are covered by global payments made by health insurance plans to hospitals and surgeons. Any increased payments required by this bill will have the effect of increasing the cost of

[3] United States General Accounting Office, Report to Congressional Committees. January 2004. Medicare: Payment Changes are Needed for Assistants-at-Surgery. GAO 04-97.

[4] United States General Accounting Office, Report to Congressional Committees. January 2004. Medicare: Payment Changes are Needed for Assistants-at-Surgery. GAO 04-97.

health care. According to the Office of Insurance Regulation, the bill does not apply to health maintenance organizations contracts.

Currently, s. 627.419(6), F.S., requires health insurance policies, plans and contracts that pay for surgical first assisting to reimburse registered nurse first assistants or their employers and employers of physician assistants for assistance in surgery. Reimbursement is required only if an assisting physician, licensed under chapters 458 or 459, F.S., would be covered, and the physician assistant or registered nurse first assistant performs such services as a substitute for the physician.

According to the Office of Insurance Regulation, the bill does not address polices renewed after the effective date. Therefore, the bill will apply prospectively to new policies issued after the effective date. It was unclear to the Office of Insurance Regulation, if this new, direct payment requirement will significantly impact claims, payments for services provided by certified surgical assistants which may be currently covered under the general reimbursement for a covered surgical procedure.

Even though the Office of Insurance Regulation states that the bill's provisions do not apply to health maintenance organization (HMO) contracts, the language of the bill states that "when any health insurance policy, health services plan or other contract provides for payment for surgical first assisting benefits or services..." If HMOs' contracts provide those services then arguably they would have to comply with the provisions of this bill.

C. SECTION DIRECTORY:

Section 1. Creates s. 458.3465, F.S., to provide definitions, performance requirements, duties and scope of practice, employment guidelines, licensure requirements, application fees and renewal fees, authority to impose penalties, specification for licensure status, title protection, rule making authority, fee guidelines, and states that supervising physicians are liable for certain actions or omissions of a certified surgical first assistant.
Section 2. Amends s. 627.419, F.S., to provide payment mechanisms for physician assistants providing surgical first assistant services, and places payment provisions for certified surgical first assistants.
Section 3. Provides that the bill will take effect on July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

The following the fiscal impact was provided by the Department of Health.

1. Revenues:

Estimated Revenue	1st Year	2nd Year
$100 initial application fee	$50,000	$5,000
$200 initial licensure fee	$100,000	$10,000
$5 unlicensed activity fee	$2,500	$250
Total Estimated Revenue	$152,500	$15,250

This bill provides that the boards, not the department, will set the fees. Assuming that the boards impose the same fees as currently provided for Anesthesiologist Assistants and Physician Assistants, the estimated revenues were based on 500 applicants in year 1 and 50 applicants in year 2. Revenues were computed based on a $100 initial application fee; a $200 initial licensure fee, and a $5 unlicensed activity fee. The bill states that the application fee may not exceed $750 and a renewal fee no more than $1,000.

2. Expenditures:

Estimated Expenditures	1st Year	2nd Year (Annualized/Recurr.)
Salaries		
.5 FTE, PG 15 –Licensure (BOM)	$17,586	$17,586
.5 FTE, PG 15 – Licensure Maint (BOM)	$17,586	$17,586
.5 FTE, PG 13 – Comm Svcs (BMS)	$12,156	$16,207
.5 FTE, PG 13 – Client Svcs (BMS)	$12,156	$16,207
.5 FTE, Sr Attorney, PG 230 (PSU)	$26,725	$35,633
1 FTE, PG 15 (PSU)	$26,379	$35,172
Expense		
Non-recurring for 5 positions	$13,955	
Recurring exp for 5 positions	$25,975	$25,975
Non-recurring exp for 1 position	$3,343	
Recurring exp w/max travel 1 position	$15,757	$15,757
Processing initial and renewal applications	$5,138	$5,138
Operating Capital Outlay		
Non-recurring for 5 positions	$10,500	
Non-recurring for 1 position	$1,900	
Human Resource Services		
6 positions	$2,358	$2,358
Total Estimated Expenditures	$191,514	$187,619

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

This may increase the cost of health care as surgeons may be able to bill for services not previously billable. Regulation of health care providers may have a positive impact on patient safety. This bill encourages all surgical assistants to get certified or face smaller employment opportunities.

D. FISCAL COMMENTS:

Boards of licensed professions with a small licensee base often operate in a deficit. Based on the number of estimated licensees, this profession is expected to operate in a deficit depending on the amount of the renewal fee, and will require subsidization from professions operating with a surplus cash balance. Expenses for administrative, complaint, investigative, and prosecution services are allocated to each board by DOH, based upon the level of services provided to that board. Allocated expenses for certified surgical first assistants could range between $19,000 and $243,000 or more annually (depending on the enforcement activity) in addition to the direct expenses shown in this analysis.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not require counties or municipalities to spend funds or take an action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill provides the Department of Health with adequate rule-making authority to implement the provisions provided for in the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Proponents for licensure of certified surgical first assistants have not provided sufficient documentation, based on the evaluation criteria established in s. 11.62, F.S., to warrant the establishment of a new profession at this time.

According to the Department of Health, the bill is similar to the regulation of Anesthesiologist Assistants; however, the following issues should be considered:

- The bill requires that applicants have certification from one of three national organizations; however, one of these organizations, The American Board of Surgical Assistants, does not require graduation from a program approved by the Commission on Accreditation of Allied Health Education Programs. As a result, the State of Kentucky will no longer accept certification from this organization for their surgical assistant certification program.

- The bill provides that the Board issues licenses and the department renews licenses. This is a typographical error and can be easily addressed.

- The bill provides that the employment arrangement of a certified surgical first assistant cannot be limited in any way by statute or rule of the board. It is unclear how this would affect the ability of the board to ensure compliance of the certified surgical first assistants and the supervising physicians with statutes and rules and to take disciplinary actions for violations thereof.

- The bill provides for reciprocity which will limit the ability of the Board to ensure that all licenses meet the same requirements for certification as a certified surgical first assistant. With licensure in one state, they could be licensed here without meeting the Florida education and licensure standards.

- The bill limits certified surgical first assistants to a "medical clinic, hospital, ambulatory surgical center, or similar medical institution." It is unclear where the certified surgical first assistant would not be able to practice.

The Board of Medicine has requested clarification of three issues: reciprocity, whether the profession would operate in a deficit, and the language of the bill which has the board issuing licenses.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

A bill to be entitled

An act relating to surgical first assistance; creating s. 458.3465, F.S.; providing definitions; providing requirements for the performance of supervising physicians; providing the duties and scope and location of practice for certified surgical first assistants; providing contracting and employment guidelines for physicians, hospitals, clinics, or ambulatory surgical centers employing certified surgical first assistants; providing licensure criteria for certified surgical first assistants; providing for application fees and licensure renewal fees; providing for licensure renewal; providing continuing education requirements; authorizing the Board of Medicine to impose penalties; providing scope of a certified surgical first assistant's license; providing for reciprocity of licenses among states; providing for inactive and delinquent status; providing that an unlicensed person who holds himself or herself out as, or indicates or implies that he or she is, licensed commits a third degree felony and is subject to applicable penalties; providing for denial, suspension, or revocation of licensure; authorizing the board to adopt rules; providing that supervising physicians may be liable for certain acts or omissions of certified surgical first assistants; providing guidelines for the use of fees collected by the board; amending s. 627.419, F.S.; providing for payments to a physician assistant under contracts providing for payment for surgical first

assisting benefits or services; including certified surgical first assistants, as defined, within certain benefits or services payment provisions; limiting application; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 458.3465, Florida Statutes, is created to read:

458.3465 Certified surgical first assistants.--

(1) DEFINITIONS.--As used in this section:

(a) "Board" means the Board of Medicine.

(b) "Certified surgical first assistant" means a person who provides primary surgical assistance to the primary surgeon during a surgical procedure, is listed on the operative record as the first assistant, and meets the qualifications for licensure under this section.

(c) "Continuing medical education" means courses recognized and approved by the board, the Liaison Council on Certification for the Surgical Technologist, the National Surgical Assistant Association, the American Board of Surgical Assistants, the American Medical Association, the American Osteopathic Association, or the Accreditation Council on Continuing Medical Education.

(d) "Direct supervision" means supervision by a delegating physician who is physically present and who personally directs delegated acts and remains immediately available to personally respond to any emergency until the patient is released from the

operating room or the physician's care and has been transferred to the care and responsibility of another physician.

(e) "Surgical assisting" means providing aid under direct supervision in exposure, hemostasis, closures, and other intraoperative technical functions that assist a physician in performing a safe operation with optimal results for the patient.

(2) PERFORMANCE OF SUPERVISING PHYSICIAN.--Each physician or group of physicians supervising a certified surgical first assistant shall be qualified in the medical areas in which the certified surgical first assistant is to perform and may be individually or collectively responsible and liable for the performance and the acts and omissions of the certified surgical first assistant.

(3) PERFORMANCE OF CERTIFIED SURGICAL FIRST ASSISTANTS.--

(a) A certified surgical first assistant may perform duties limited to the scope of certification in surgical assisting functions while under the direct supervision of a physician.

(b) The scope of practice of a certified surgical first assistant is limited to surgical assisting and tasks delegated by the supervising physician.

(c) A certified surgical first assistant may only perform his or her duties in a medical clinic, hospital, ambulatory surgical center, or similar medical institution.

(4) EMPLOYMENT OF CERTIFIED SURGICAL FIRST ASSISTANTS.--

(a) A physician or hospital is not required to contract with a certified surgical first assistant.

(b) A health maintenance organization, preferred provider organization, or health benefit plan shall not require a physician, hospital, clinic, or ambulatory surgery center to contract with a certified surgical first assistant as a condition of payment to a certified surgical first assistant.

(c) The employment arrangement of a certified surgical first assistant shall not be limited in any way by rule of the board or by statute.

(5) CERTIFIED SURGICAL FIRST ASSISTANT LICENSURE.--

(a) A person desiring to be licensed as a certified surgical first assistant shall apply to the board. The board shall issue a license to any person determined by the board as having met the following requirements:

1. Is at least 18 years of age.

2. Holds and maintains certification from one of the following recognized certifying agencies:

a. The Liaison Council on Certification for the Surgical Technologist.

b. The National Surgical Assistant Association.

c. The American Board of Surgical Assistants.

3. Has completed the application form and remitted an application fee not to exceed $750 as set by the board. An application for licensure made by a certified surgical first assistant shall include:

a. A certificate from one of the recognized certifying agencies specified in subparagraph 2.

b. A sworn statement of any prior felony convictions.

c. A sworn statement of any previous revocation or denial of licensure or certification.

(b) A license shall be renewed biennially. Each renewal shall include:

1. A renewal fee not to exceed $1,000 as set by the board.

2. A sworn statement of no felony convictions in the previous 2 years.

(c) Each licensed certified surgical first assistant shall biennially complete 40 hours of continuing medical education or shall hold a current certificate issued by a recognized certifying agency listed in subparagraph (a)2.

(d) The board may impose any of the penalties authorized under ss. 456.072 and 458.331(2) upon a certified surgical first assistant if the certified surgical first assistant or the supervising physician has been found guilty of or is being investigated for any act that constitutes a violation of this chapter or chapter 456.

(e) A certified surgical first assistant's license:

1. Does not authorize the licensee to engage in the practice of medicine or professional nursing.

2. Is not required of a registered nurse, an advanced registered nurse practitioner, a registered nurse first assistant, or a physician assistant as a condition of employment.

(6) RECIPROCITY.--The department shall allow reciprocity to certified surgical first assistants who are determined by the board to:

(a) Be licensed in other states and who are in good standing with their state of licensure and their certifying agency.

(b) Have paid appropriate licensure fees.

(c) Have complied with all other requirements of the board.

(7) INACTIVE AND DELINQUENT STATUS.--A license on inactive or delinquent status may be reactivated only as provided in s. 456.036.

(8) PENALTY.--A person who has not been licensed by the board and approved by the department and who holds himself or herself out as a licensed certified surgical first assistant or who uses any other term in indicating or implying that he or she is a licensed certified surgical first assistant commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(9) DENIAL, SUSPENSION, OR REVOCATION OF LICENSURE.--The board may deny, suspend, or revoke a certified surgical first assistant license if the board determines that the certified surgical first assistant has violated this chapter.

(10) RULES.--The board may adopt rules to administer this section.

(11) LIABILITY.--Each supervising physician using a certified surgical first assistant may be liable for acts or omissions of the certified surgical first assistant acting under the physician's supervision and control.

(12) FEES.--The fees collected by the board under this section shall be used for the licensure and regulation of

certified surgical first assistants in accordance with this section.

Section 2. Subsection (6) of section 627.419, Florida Statutes, is amended to read:

627.419 Construction of policies.--

(6)(a) Notwithstanding any other provision of law, when any health insurance policy, health care services plan, or other contract provides for payment for surgical first assisting benefits or services, the policy, plan, or contract is to be construed as providing for payment to a physician assistant or registered nurse first assistant or employers of a physician assistant or registered nurse first assistant who performs such services that are within the scope of a physician assistant's or a registered nurse first assistant's professional license. ~~The provisions of~~ This paragraph applies ~~subsection apply~~ only if reimbursement for an assisting physician, licensed under chapter 458 or chapter 459, would be covered and a physician assistant or a registered nurse first assistant who performs such services is used as a substitute.

(b)1. Notwithstanding any other provision of law, when any health insurance policy, health care services plan, or other contract provides for payment for surgical first assisting benefits or services, the policy, plan, or contract is to be construed as providing for payment to a certified surgical first assistant or to the employer of a certified surgical first assistant who performs such services that are assigned by the supervising physician or osteopathic physician. This paragraph applies only if reimbursement for an assisting physician,

licensed under chapter 458 or chapter 459, would be covered and the certified surgical first assistant who performs such services is used as a substitute. As used in this paragraph, the term "certified surgical first assistant" means a person who is a licensed health care provider who is directly accountable to a physician licensed under chapter 458 or an osteopathic physician licensed under chapter 459 and who is certified by the National Surgical Assistant Association, the Liaison Council on Certification for the Surgical Technologist, or the American Board of Surgical Assistants.

2. This paragraph does not require an insurer to directly reimburse a certified surgical first assistant if the certified surgical first assistant is paid or will be paid for a surgical procedure by the health care facility at which the surgical procedure is performed.

Section 3. This act shall take effect July 1, 2006.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 611 Patient Records
SPONSOR(S): Bucher and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 2500

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee		Hamrick	Mitchell
2) Health Care Appropriations Committee			
3) Health & Families Council			
4)			
5)			

SUMMARY ANALYSIS

Outsourcing of medical records across borders raises critical privacy issues. As confidential information is routed offshore, legal protections and recourse do not follow.

The bill provides that a licensed facility must disclose to patients and receive written consent before any individually identifiable patient record can be transmitted to a site outside of the United States.

The bill also provides that any entity which contracts or subcontracts with a licensed facility must disclose whether any individually identifiable information will be transmitted outside of the United States.

The bill provides that a patient may revoke their consent in writing at any time. A licensed facility may not discriminate against an individual who may deny consent by refusing to provide health care services.

The bill takes effect on July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Safeguard individual liberty -The bill requires licensed facilities, which transmit records outside of the United States, to receive written consent from their patients.

B. EFFECT OF PROPOSED CHANGES:

The bill provides that if any record of patient treatment is transmitted to a site outside of the United States, the licensed facility[1] must disclose this fact to their patients and receive written consent on an annual basis. The bill also provides that if a licensed facility contracts or subcontracts with another entity that receives individually identifiable health information, the entity must disclose to the licensed facility whether any of the information will be transmitted outside of the United States.

The bill provides that a patient may revoke their consent in writing at any time. An exception to this requirement may occur when a patient is seeking health care services, such as diagnosis or treatment, outside of the United States. In this instance, the licensed facility must use a form to obtain consent to transmit the patients individually identifiable health information outside of the United States.

The consent form must be a separate document, not attached to any other document, that is dated and signed by the patient, and clearly discloses to the patient that "by signing, the patient is consenting to the transmission of his or her individually identifiable health information to a site outside of the United States where the information is not protected by United States confidentiality laws." The consent form must also disclose that the patient must renew their consent on an annual basis and may revoke consent at any time, along with the procedures by which consent may be revoked.

The bill states that a licensed facility may not discriminate against an individual who may deny consent by refusing to provide health care services.

BACKGROUND

Currently, Florida Statutes do not address nor prohibit the outsourcing of any health care service including transcription, to sites outside of the United States.

Outsourcing

Outsourcing raises critical privacy issues as financial, credit, personal identification, and medical records are sent across borders. As confidential information is routed offshore, legal protections and recourse do not follow.[2]

In 2003, a medical transcriber in Pakistan threatened to post a patient's records on-line unless the University of California San Francisco (UCSF) Medical Center paid the wages owed to her by the U.S. subcontractor that had sent the work to her. The hospital's transcription work had already been subcontracted from a Sausalito-based transcription firm to two U.S. sources before being subcontracted a third time to the transcriber in Pakistan. Heartland Information Services, an Ohio-

[1] A "licensed facility" is a hospital, ambulatory surgical center, or mobile surgical facility licensed in accordance to Florida Statute. See s. 395.002(17), F.S.

[2] From an article published by the National Labor Caucus of State Legislators titled "Model Health Care Consumer Protection Act."

based company that sends medical record work to India, received a similar threat from a group of disgruntled employees in Bangalore, India.[3]

The Health Insurance Portability and Accountability Act and the Privacy Rule

The Health Insurance Portability and Accountability Act of 1996 (HIPPA), required the Secretary of the Department of Health and Human Services to publicize standards for the electronic exchange, privacy, and security of health information. HIPPA did not enact privacy legislation, so the Department of Health and Human Services developed a proposed rule, called the "Privacy Rule."

Released in December 2002, the Privacy Rule addresses individually identifiable health information, which apply to health plans, health care clearinghouses, and any health care provider who transmits health information in an electronic format inside the United States. The Privacy Rule protects all "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral.

An entity that is covered by the Privacy Rule may not use or disclose protected health information except: (1) as the Privacy Rule permits and (2) if the individual who is the subject of the information authorizes in writing. A covered entity must obtain the individual's written authorization for any use or disclosure of protected health information that is not for treatment, payment, or health care operations or otherwise permitted or required by law.

Once individually identifiable information leaves the United States the protections granted by HIPPA and the Privacy Rule are difficult to enforce.

C. SECTION DIRECTORY:

Section 1. Amends s. 395.3025, F.S., to require a licensed facility to disclose and receive consent from patients to send identifiable patient information outside the United States.
Section 2. Provides an effective date of July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

[3] From an article published on www.CommonDreams.org titled "Gap in Basic Consumer Safeguards Encouraging Offshoring," by Lori Wallach (April 21, 2004).

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Indeterminate. See "D. Fiscal Comments."

D. FISCAL COMMENTS:

All licensed facilities that transmit individual identifiable information outside of the United States will be required to gain consent and produce consent forms for their patients. If patients refuse to provide consent, the licensed facility will have to seek similar health care services inside the United States.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or take an action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

No additional rulemaking authority is required to implement the provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

A bill to be entitled

An act relating to patient records; amending s. 395.3025, F.S.; requiring disclosure by a licensed facility concerning individually identifiable health information transmitted to a site outside the United States; requiring notice to and consent of the patient; providing for renewal and revocation of consent; providing for a consent form and contents thereof; prohibiting discrimination based on refusal to grant consent; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (7) of section 395.3025, Florida Statutes, is amended to read:

395.3025 Patient and personnel records; copies; examination; transmission of records; consent.--

(7)(a) If the content of any record of patient treatment is provided under this section, the recipient, if other than the patient or the patient's representative, may use such information only for the purpose provided and may not further disclose any information to any other person or entity, unless expressly permitted by the written consent of the patient. A general authorization for the release of medical information is not sufficient for this purpose. The content of such patient treatment record is confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(b) Absent a specific written release or authorization permitting utilization of patient information for solicitation or marketing the sale of goods or services, any use of that information for those purposes is prohibited.

(c) A person or entity that has contracted or subcontracted with a licensed facility as defined in s. 395.002(17) to receive individually identifiable health information shall disclose to the licensed facility whether any of the information will be transmitted to a site outside the United States.

(d) A licensed facility, or person or entity that has contracted or subcontracted with a licensed facility, shall not transmit individually identifiable health information to a site outside the United States unless all of the following apply:

1. The licensed facility discloses to the patient upon admission, or as soon as practicable after admission, that his or her individually identifiable health information may be transmitted to a site outside the United States.

2. The licensed facility obtains written consent from the patient to transmit his or her individually identifiable health information to a site outside the United States.

3. The consent of the patient has been granted or renewed on an annual basis.

4. The patient may revoke consent in writing at any time.

(e) Except for a request for health care services initiated by a person seeking diagnosis or treatment outside the United States, a licensed facility shall utilize a form to obtain consent to transmit individually identifiable health

information to a site outside the United States. The form shall meet the following criteria:

1. It shall be a separate document and shall not be attached to any other document.

2. It shall be dated and signed by the patient whose health care information is identifiable.

3. It shall clearly disclose all of the following:

a. By signing, the patient is consenting to the transmission of his or her individually identifiable health information to a site outside the United States where the information is not protected by United States confidentiality laws.

b. The consent of the patient must be renewed on an annual basis.

c. The patient may revoke consent at any time.

d. The procedure by which consent may be revoked.

A licensed facility shall not discriminate against an individual or deny an individual health care service because the individual has not provided consent pursuant to this subsection.

Section 2. This act shall take effect July 1, 2006.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 805 CS Health Care Insurers and ID Cards
SPONSOR(S): Benson
TIED BILLS: **IDEN./SIM. BILLS:** SB 1274

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Insurance Committee	18 Y, 0 N, w/CS	Tinney	Cooper
2) Health Care Regulation Committee		Bell ATB	Mitchell
3) Commerce Council			
4)			
5)			

SUMMARY ANALYSIS

The bill requires individual and group health insurers and HMOs to provide an identification card to policyholders and subscribers. Although the bill amends various sections of law, the requirements for the information to be contained on the health insurance identification card is the same, whether the requirements specify an identification card for an individual or group health policy or an HMO. Under the bill, a health insurance ID card is required to include the following information:

1. Name of organization issuing or administering the health policy;
2. Name of person or family covered by the policy;
3. Type of health care plan or network;
4. Member ID number, contract number, or policy or group number;
5. Telephone number or electronic address for use in receiving insurer authorization;
6. Telephone number or electronic address for use in determining estimated co-payments, deductibles, co-insurance, or maximum out-of-pocket expenses for the insured and covered dependents; and
7. National identification code for insurer, if available.

All insurers are required to present the required ID card information in an easy-to-read manner. The bill also authorizes an insurer to encode the information on a magnetic strip or a smart card, or through other electronic technology.

The bill also amends several other sections of law to correct cross-references.

State agencies report they will not incur costs to implement the bill. Insurers offering individual and group health policies, along with health maintenance organizations (HMOs), likely will incur costs to design, print, and distribute the health ID cards required by the bill. The cost to health insurers is not quantifiable, however, as it is dependent upon the number of policyholders and covered dependents of each health insurer.

The effective date of the bill is July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government; Empower Families; and Promote Personal Responsibility—Under the bill, health insurers and HMOs are required to provide an insurance ID card containing specified information to policyholders and subscribers and their respective covered dependents.

B. EFFECT OF PROPOSED CHANGES:

Insurance Regulation and General Provisions

In Florida, regulation of the insurance industry is shared by the Department of Financial Services (DFS) and the Office of Insurance Regulation (OIR). The state's Chief Financial Officer (CFO) heads DFS while the head of OIR is the Governor and Cabinet members sitting as the Financial Services Commission. Generally, OIR is responsible for granting a certificate of authority or license to an insurer; a domestic insurer, i.e., an insurer based in Florida, must possess a certificate of authority in order to conduct business in Florida.

Similarly, many insurers are required by law to seek OIR approval for their rates, or the prices they charge for coverage, and approval of the insurance forms they use for issuing policies. The Office of Insurance Regulation investigates allegations of fraud against insurers and administers state laws governing the financial reserve requirements imposed on insurers. The regulation and licensure of insurance agents and agencies is the purview of DFS. Staff of DFS also provides consumer information and assistance through the Division of Consumer Services.

Florida's Current Health Insurance Market

Various federal and state laws regulate Florida's health insurance market. The result of the various laws is that Florida's health insurance market is segmented into various groups, including self-insured groups or health plans, large groups of 51 or more participants, small groups ranging in size from 1 to 50 members, individual health policies, health maintenance organizations (HMOs), and out-of-state groups. Each segment of the market may be further divided into sub-groups, both in Florida, and in most other states, however, the Florida Insurance Code governs the activities, policies, and premiums of health insurance within the market segments serving policyholders in Florida.

Chapter 627, F.S., governs rates and contracts for all types of insurance available in Florida, including life, health, property, automobile, credit life and disability, workers' compensation, and title, among other types of policies. For example, part VI, chapter 627, F.S., governs health insurance policies for individuals, while part VII of ch. 627, F.S., governs group, blanket, and franchise health insurance policies. Part II of ch. 627, F.S., outlines the requirements insurers must include in their policies, i.e., contracts.

Chapter 641, F.S., governs health care service programs. This includes HMOs, prepaid health clinics, and other health care services.

Currently, laws governing health insurers and their policies (i.e., contracts) do not require insurers to provide an insurance card to policyholders and subscribers. The laws generally require health insurers to provide policyholders either with an outline of benefits and coverage or a member/policyholder

handbook, however.[1] Many health insurers currently issue insurance cards to their policyholders, however, each insurer determines the type of information to be printed on the card.

Auto Insurance: Proof of Coverage

Laws governing auto insurance in Florida require insurers to provide policyholders with proof of insurance.[2] Such proof generally is provided through an insurance card. Proof of auto insurance typically contains both the policyholder's and insurer's name; a telephone number for the insurer; the policy number; a brief description of the covered auto(s), including manufacturer, model, and vehicle identification number (VIN). The back of the proof of auto insurance also may contain information and phone numbers for use in reporting an accident to the insurer.

Under Florida law, the owner of a motor vehicle is required to register his or her vehicle annually.[3] As part of the registration process, a vehicle owner is required to show proof of insurance coverage with minimum benefits for personal injury protection (PIP) and property damage.[4]

Health Insurance Policies: Changes Proposed by the Bill

The bill requires individual and group health insurers and HMOs to provide an identification card to policyholders and subscribers. Although the bill amends various sections of law, the requirements for the information to be contained on the health insurance identification card are the same, whether the requirements specify an identification card for an individual or group health policy or an HMO. For example, under the bill, a health insurance ID card is required to include the following information:

1. Name of organization issuing or administering the health policy;
2. Name of person or family covered by the policy;
3. Type of health care plan or network;
4. Member ID number, contract number, or policy or group number;
5. Telephone number or electronic address for use in receiving insurer authorization;
6. Telephone number or electronic address for use in determining estimated co-payments, deductibles, co-insurance, or maximum out-of-pocket expenses for the insured and covered dependents; and
7. National identification code for insurer, if available.

Part VI of ch. 627, F.S., specifies the requirements for health insurance policies sold to individuals in Florida. Section 627.642, F.S., regarding the outline of coverage for individual policies, is amended to require insurers offering individual major medical health insurance policies to issue an insurance ID card to their policyholders.

The bill also amends s. 627.657, F.S., regarding group health insurance policies to require group insurers to issue an ID card to their policyholders. Similarly, the bill amends s. 641.31, F.S., relating to HMO contracts, to require HMOs to issue an ID card to their respective members.

All insurers are required to present the required ID card information in an easy-to-read manner. The bill also authorizes an insurer to encode the information on a magnetic strip or a smart card, or through

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[1] *See* s. 627.642, F.S., (2005) relating to the outline of coverage for individual health insurance policies. Similarly, *see* s. 627.657, F.S., (2005) prescribing the provisions and form of group health insurance policies. *See* also ss. 627.64725 and 641.185, F.S., (2005) outlining the requirements for HMO plans to provide the conditions of their respective plans either on the policy or in a member handbook.

[2] *See*, e.g., ss. 320.02 and 627.936(9)(a), F.S., (2005) regarding proof of insurance coverage for motor vehicles and the requirement for auto insurers to provide notice to the Department of Highway Safety and Motor Vehicles regarding issuance, non-renewal, and cancellation of auto coverage.

[3] Section 320.02, F.S., (2005).

[4] *See*, e.g., s. 627.733(3) for requirements relating to PIP coverage and s. 324.022, F.S., (2005) for the law specifying auto insurance coverage for property damage.

other electronic technology. Several other sections of law are amended by the bill to correct cross-references.

C. SECTION DIRECTORY:

Section 1. - Amends s. 627.642, F.S., relating to health coverage provided under individual health insurance policies.

Section 2. - Amends s. 627.657, F.S., relating to health coverage provided by group, blanket, and franchise health insurance policies.

Section 3. - Amends s. 641.31, F.S., relating to health maintenance (i.e., HMOs) contracts and coverage.

Section 4. - Amends s. 383.145, F.S., relating to hearing screening for infants and newborns to correct a cross-reference.

Section 5. - Amends s. 641.185, F.S., relating to HMO subscriber protections, to correct a cross-reference.

Section 6. - Amends s. 641.2018, F.S., relating to coverage for home health care under an HMO contract, to correct a cross-reference.

Section 7. - Amends s. 641.3107, F.S., relating to the delivery of HMO contracts to subscribers, to correct a cross-reference.

Section 8. - Amends s. 641.3922, F.S., relating to HMO conversion policies, to correct a cross-reference.

Section 9. - Amends s. 641.513, F.S., relating to emergency services provided by HMOs, to correct a cross-reference.

Section 10. - Provides an effective date for the bill of July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None. The Department of Financial Services and the Department of Health, the Agency for Health Care Administration, and OIR all indicate the bill will have no financial impact on the respective departments and agencies.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

If a health insurer does not currently provide a policyholder with an insurance card, the health insurer will incur costs to provide the insurance ID card required by the bill. It is not possible to estimate the costs for issuing such cards, however, as the cost depends on the number of policyholders and dependents covered by each health plan.

Many health insurers and HMOs currently provide their policyholders and members with an insurance card. Most current health insurer cards do not contain all of the information required by the bill, however. This likely will mean the existing health insurance cards will be replaced the by the respective insurer or HMO in order to include the information required by the bill. In some cases, the requirements of the bill may necessitate the redesign of current insurance cards in order to include the information required by the bill.

D. FISCAL COMMENTS:

The requirements for health insurer ID cards under the bill become effective July 1, 2006. As a result, health insurers and HMOs will be required to provide their policyholders and dependents or HMO members with the required health insurer ID card by July 1, 2006. This could be a hardship for large insurers who may need extra time to design the card, order it to be printed, and mail it to their policyholders or HMO members and their covered dependents.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

None.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Many laws imposing requirements on insurers also grant rulemaking authority to OIR and the Financial Services Commission, however this bill does not. This bill is specific in describing the information to be contained on the health insurance ID card. As a result, insurers should implement the provisions of the bill without additional direction from an administrative rule.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

At its March 9, 2006 meeting, the Insurance Committee adopted five amendments to the bill to clarify the types of information health insurers must include on the health ID cards required by the bill. The amendments made the following changes to the bill:

- specifies that individual major medical health insurance policies (rather than **all** individual policies) must provide policyholders with an ID card;

- changes the information to be included by health insurers on ID cards to terminology used in most health insurance policies;
- changes the information to be included by health insurers on ID cards to terminology frequently used in health policies and recognizes federal rules adopted under the Health Insurance Portability and Accountability Act (HIPAA) govern the type of information an insurer may disclose;
- allows insurers to provide required information electronically or embedded in magnetic strips on smart cards; and
- specifies that an ID card issued by an HMO must identify the insurer as an HMO.

This analysis has been updated to reflect the amendments adopted by the Insurance Committee at its March 9, 2006 meeting.

CHAMBER ACTION

The Insurance Committee recommends the following:

Council/Committee Substitute

Remove the entire bill and insert:

A bill to be entitled

An act relating to policies, contracts, and programs for the provision of health care services; amending s. 627.642, F.S.; requiring an identification card containing specified information to be given to insureds who have health and accident insurance; amending s. 627.657, F.S.; requiring an identification card containing specified information to be given to insureds under group health insurance policies; amending s. 641.31, F.S.; requiring an identification card to be given to persons having health care services through a health maintenance contract; amending ss. 383.145, 641.185, 641.2018, 641.3107, 641.3922, and 641.513, F.S.; conforming cross-references to changes made by the act; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (3) is added to section 627.642, Florida Statutes, to read:

627.642 Outline of coverage.--

(3) In addition to the outline of coverage, a major medical policy must be accompanied by an identification card that contains, at a minimum:

(a) The name of the organization issuing the policy or name of the organization administering the policy, whichever applies.

(b) The name of the covered person or covered family, whichever applies.

(c) Type of plan or name of network.

(d) The member identification number, contract number, and policy or group number, if applicable.

(e) A contact phone number or electronic address for authorizations.

(f) A phone number or electronic address whereby the covered person or hospital, physician, or other person rendering services covered by the policy may obtain information necessary to estimate patient financial responsibility, in compliance with privacy rules under the Health Insurance Portability and Accountability Act.

(g) The national plan identifier, when available.

The identification card must present the information in a readily identifiable manner or, alternatively, the information may be embedded on the card and available through magnetic stripe or smart card. The information may also be provided through other electronic technology.

Section 2. Present subsection (2) of section 627.657, Florida Statutes, is renumbered as subsection (3), and a new subsection (2) is added to that section, to read:

627.657 Provisions of group health insurance policies.--

(2) The policy must be accompanied by an identification card that contains, at a minimum:

(a) The name of the organization issuing the policy or name of the organization administering the policy, whichever applies.

(b) The name of the covered person or covered family, whichever applies.

(c) Type of plan or name of network.

(d) The member identification number, contract number, and policy or group number, if applicable.

(e) A contact phone number or electronic address for authorizations.

(f) A phone number or electronic address whereby the covered person or hospital, physician, or other person rendering services covered by the policy may obtain information necessary to estimate patient financial responsibility, in compliance with privacy rules under the Health Insurance Portability and Accountability Act.

(g) The national plan identifier, when available.

The identification card must present the information in a readily identifiable manner or, alternatively, the information may be embedded on the card and available through magnetic

stripe or smart card. The information may also be provided through other electronic technology.

Section 3. Present subsections (5) through (40) of section 641.31, Florida Statutes, are renumbered as subsections (6) through (41), respectively, and a new subsection (5) is added to that section, to read:

641.31 Health maintenance contracts.--

(5) The contract, certificate, or member handbook must be accompanied by an identification card that contains, at a minimum:

(a) The name of the organization offering the contract or name of the organization administering the contract, whichever applies.

(b) The name of the covered person or covered family, whichever applies.

(c) A statement that the health plan is a health maintenance organization.

(d) The member identification number, contract number, and group number, if applicable.

(e) A contact phone number or electronic address for authorizations.

(f) A phone number or electronic address whereby the covered person or hospital, physician, or other person rendering services covered by the contract may obtain information necessary to estimate patient financial responsibility, in compliance with privacy rules under the Health Insurance Portability and Accountability Act.

(g) The national plan identifier, when available.

The identification card must present the information in a readily identifiable manner or, alternatively, the information may be embedded on the card and available through magnetic stripe or smart card. The information may also be provided through other electronic technology.

Section 4. Paragraph (j) of subsection (3) of section 383.145, Florida Statutes, is amended to read:

383.145 Newborn and infant hearing screening.--

(3) REQUIREMENTS FOR SCREENING OF NEWBORNS; INSURANCE COVERAGE; REFERRAL FOR ONGOING SERVICES.--

(j) The initial procedure for screening the hearing of the newborn or infant and any medically necessary followup reevaluations leading to diagnosis shall be a covered benefit, reimbursable under Medicaid as an expense compensated supplemental to the per diem rate for Medicaid patients enrolled in MediPass or Medicaid patients covered by a fee for service program. For Medicaid patients enrolled in HMOs, providers shall be reimbursed directly by the Medicaid Program Office at the Medicaid rate. This service may not be considered a covered service for the purposes of establishing the payment rate for Medicaid HMOs. All health insurance policies and health maintenance organizations as provided under ss. 627.6416, 627.6579, and 641.31(31) ~~(30)~~, except for supplemental policies that only provide coverage for specific diseases, hospital indemnity, or Medicare supplement, or to the supplemental polices, shall compensate providers for the covered benefit at the contracted rate. Nonhospital-based providers shall be

eligible to bill Medicaid for the professional and technical component of each procedure code.

Section 5. Paragraphs (b) and (i) of subsection (1) of section 641.185, Florida Statutes, are amended to read:

641.185 Health maintenance organization subscriber protections.--

(1) With respect to the provisions of this part and part III, the principles expressed in the following statements shall serve as standards to be followed by the commission, the office, the department, and the Agency for Health Care Administration in exercising their powers and duties, in exercising administrative discretion, in administrative interpretations of the law, in enforcing its provisions, and in adopting rules:

(b) A health maintenance organization subscriber should receive quality health care from a broad panel of providers, including referrals, preventive care pursuant to s. 641.402(1), emergency screening and services pursuant to ss. 641.31(13) ~~(12)~~ and 641.513, and second opinions pursuant to s. 641.51.

(i) A health maintenance organization subscriber should receive timely and, if necessary, urgent grievances and appeals within the health maintenance organization pursuant to ss. 641.228, 641.31(6) ~~(5)~~, 641.47, and 641.511.

Section 6. Subsection (1) of section 641.2018, Florida Statutes, is amended to read:

641.2018 Limited coverage for home health care authorized.--

(1) Notwithstanding other provisions of this chapter, a health maintenance organization may issue a contract that limits

coverage to home health care services only. The organization and the contract shall be subject to all of the requirements of this part that do not require or otherwise apply to specific benefits other than home care services. To this extent, all of the requirements of this part apply to any organization or contract that limits coverage to home care services, except the requirements for providing comprehensive health care services as provided in ss. 641.19(4), (11), and (12), and 641.31(1), except ss. 641.31(10) ~~(9)~~, (13) ~~(12), (17)~~, (18), (19), (20), (21), (22), and (25) ~~(24)~~ and 641.31095.

Section 7. Section 641.3107, Florida Statutes, is amended to read:

641.3107 Delivery of contract.--Unless delivered upon execution or issuance, a health maintenance contract, certificate of coverage, or member handbook shall be mailed or delivered to the subscriber or, in the case of a group health maintenance contract, to the employer or other person who will hold the contract on behalf of the subscriber group within 10 working days from approval of the enrollment form by the health maintenance organization or by the effective date of coverage, whichever occurs first. However, if the employer or other person who will hold the contract on behalf of the subscriber group requires retroactive enrollment of a subscriber, the organization shall deliver the contract, certificate, or member handbook to the subscriber within 10 days after receiving notice from the employer of the retroactive enrollment. This section does not apply to the delivery of those contracts specified in s. 641.31(14) ~~(13)~~.

Section 8. Paragraph (a) of subsection (7) of section 641.3922, Florida Statutes, is amended to read:

641.3922 Conversion contracts; conditions.--Issuance of a converted contract shall be subject to the following conditions:

(7) REASONS FOR CANCELLATION; TERMINATION.--The converted health maintenance contract must contain a cancellation or nonrenewability clause providing that the health maintenance organization may refuse to renew the contract of any person covered thereunder, but cancellation or nonrenewal must be limited to one or more of the following reasons:

(a) Fraud or intentional misrepresentation, subject to the limitations of s. 641.31(24) ~~(23)~~, in applying for any benefits under the converted health maintenance contract.~~,~~

Section 9. Subsection (4) of section 641.513, Florida Statutes, is amended to read:

641.513 Requirements for providing emergency services and care.--

(4) A subscriber may be charged a reasonable copayment, as provided in s. 641.31(13) ~~(12)~~, for the use of an emergency room.

Section 10. This act shall take effect July 1, 2006.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1093 Physicians
SPONSOR(S): Altman and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1410

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee		Hamrick	Mitchell
2) Health Care Appropriations Committee			
3) Health & Families Council			
4)			
5)			

SUMMARY ANALYSIS

HB 1093 requires the Division of Health Access and Tobacco within the Department of Health to monitor, evaluate, and report on the supply, distribution and specialty of allopathic and osteopathic physicians in Florida. The bill requires the division to utilize data that is available from public and private sources.

The bill requires physicians seeking licensure to submit their credentials to the Federation Credentials Verifications Services of the Federation of State Medical Boards for verification. The federation verifies the submitted information and certifies it as a primary source document from which a physician profile may be created and sent to employers, hospitals, and the Board of Medicine who then may evaluate an individual's eligibility for licensure.

Fiscal Impact: According to the Department of Health, the cost to implement the provisions of the bill will be approximately $161,000 for the first year and approximately $110,000 each succeeding year.

The bill takes effect on October 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provides limited government-The bill requires the Division of Health Access and Tobacco to monitor, evaluate and report on the supply and demand of physicians in the state. The bill requires physicians to submit information and pay a fee to a private credentialing organization.

B. EFFECT OF PROPOSED CHANGES:

The bill requires the Division of Health Access and Tobacco within the Department of Health to monitor, evaluate, and report on the supply and distribution of physicians in the state. The division is required to develop a strategy to track and analyze, on an ongoing basis, the distribution of licensed physicians by specialty and geographic location. The division must use public and private resources for available data. A report must be submitted to the Governor, the President of the Senate, and the Speaker of the House each year, starting January 1, 2008.

The bill adds a requirement to the licensure by endorsement and licensure by examination provisions, which requires physicians who are seeking licensure to submit their core credentials to the Federation Credentials Verification Services of the Federation of State Medical Boards for verification.

The bill reenacts s. 458.347(7)(b), F.S., to incorporate the language requiring physicians to submit their core credentials to the Federation Credentials Verification Services. This section is included in the bill as a technicality in order to ensure that the amendment to s. 458.311(1)(g), F.S. dealing with the credentialing by the federation is applied.

The reenacted section relates to physician assistants, but also provides an alternative pathway for foreign trained physicians to gain licensure to practice as a physician assistant in Florida. The reenacted section also allows for the administration of a state examination. Based on statutory construction, concern was raised that reenacting this section of law will supersede s. 456.017(1)(c), F.S., which prohibits the Department of Health and boards from administering a state-developed written examination if a national examination is available. For this reason, language was added to the directory of Section 4 that stipulates that reenacting s. 458.347(7)(b), F.S., does not supersede s. 456.017(1)(c), F.S.

The bill provides an appropriation from the General Revenue Fund for the Department of Health to implement the provisions of this bill for the 2006-2007 fiscal year. The bill may be not implemented unless funds are appropriated.

PRESENT SITUATION

Physician Workforce Data

Recently, the Council on Graduate Medical Education, a national advisory organization that makes recommendations on the adequacy of the supply and distribution of physicians, predicted that the demand for physicians, nationally, would significantly outpace the supply. In Florida, the costs of medical malpractice insurance, the recent adoption of a constitutional amendment that prohibits licensure or continued licensure of physicians who have committed three or more incidents of medical malpractice, and other variables have affected the number of students applying to medical schools in Florida. The number of allopathic and osteopathic physicians applying for licensure and practicing in Florida has also been impacted.

The statewide collection of physician data and its analysis is fragmented in Florida and under the purview of different agencies. Currently, there is no centralized physician workforce database that is available to provide objective statewide information on physician practice and manpower needs.

Under s. 408.05, F.S., the State Center for Health Statistics within the Agency for Health Care Administration (AHCA) must collect data on health resources, including physicians, dentists, nurses, and other health care professionals. The Division of Health Access and Tobacco within DOH administers several programs that relate to physician access. The Florida Medicaid program in AHCA has claims data for physicians participating in the Medicaid program. Although several entities collect information on Florida physicians, there is no centralized responsibility for statewide collection and analysis of health workforce data, including physician data.

Current Statutory Licensure Requirements

Chapter 458, F.S., governs the practice of allopathic medicine. The bill adds language to two sections (ss. 458.311 and 458.313, F.S.) relating to licensure by examination and by endorsement, that requires physicians to submit core credentials to the Federation of State Medical Boards for verification.

Currently, an applicant seeking licensure in Florida must submit specified information regarding education, training, and discipline to the Board of Medicine and shall submit an application fee not to exceed $500.

Credentialing Process by the Board of Medicine

As part of the initial licensure process, the staff of the Board of Medicine verifies an applicant's core credentials. The core credentials include medical education, all postgraduate medical training, national licensure examination history, Educational Commission for Foreign Medical Graduates (ECFMG) certification, any current staff privileges, and any physician licenses held in other states, disciplinary history, and medical malpractice claims. Primary source verification of a physician licensure applicant's credentials can be a laborious process, which results in substantial delay in a board's evaluation of an applicant's credentials.

The Florida Board of Medicine encourages, but does not require, licensure applicants to use the Federation Credentials Verification Service (FCVS) to have the applicant's core credentials verified. A one time fee is assessed by the federation for this service of approximately $275. Additional fees or surcharges may be assessed depending upon what additional information is needed.

Federation Credentials Verification Service offered by the Federation of State Medical Boards

Federation Credentials Verification Service (FCVS) was established in September 1996 to provide a centralized, uniform process for state medical boards to obtain a verified, primary source record of a physician's core medical credentials. The FCVS acts as a repository of information for physicians and establishes a confidential, lifetime professional portfolio with FCVS which can be forwarded, at the physician's request, to any state medical board that has established an agreement with FCVS, hospital, health care or any other entity. FCVS obtains primary source verification of medical education, postgraduate training, examination history, board action history, board certification and identity.

This service is designed to lighten the workload of credentialing staff and reduce duplication of effort by gathering, verifying and permanently storing the physician's and/or physician assistant's credentials in a central repository at the federation.

Currently, 38 states *accept* a physician's credentials that are verified by the federation, including Florida. Nine states currently *require* verification by the federation. The bill will make Florida the tenth state to *require* physicians to get verification by the federation.

Hospital Credentialing and Federation Credentials Verification Service

Currently, hospitals are not required to recognize the Federation Credentials Verification Service (FCVS). According to information received from the FCVS, limited numbers of hospitals have accepted credentialing from the federation. Since 2001, only 69 medical groups or health care facilities in the state accepted FCVS physician profiles. In comparison, (as of 2005) there were 264 licensed hospitals in the state.

Hospitals and other health care entities are required to meet certain accreditation standards that are set by such entities as the Joint Commission (JCAHO), and the National Committee for Quality Assurance (NCQA) and they are ultimately responsible for the accuracy of employee's credentials. For this reason, a physician could submit their credentials to the FCVS and still be responsible for submitting the identical information to a hospital.

C. SECTION DIRECTORY:

Section 1. Creates s. 381.0304, F.S., to require the Division of Health Access and Tobacco within the Department of Health to monitor, evaluate, and report on the supply and distribution of physicians and osteopathic physicians in the state.
Section 2. Amends s. 458.311, F.S., to require an individual seeking licensure by examination as a physician must submit their core credentials to the Federation Credentials Verification Services of the Federation of State Medical Boards for verification.
Section 3. Amends s. 458.313, F.S., to require an individual seeking licensure by endorsement as a physician to submit their core credentials to the Federation Credentials Verification Services of the Federation of State Medical Boards for verification.
Section 4. Reenacts s. 458.347, F.S., for the purpose of incorporating the amendment to s. 458.311, F.S., and provides that the reenactment is not intended to supersede s. 456.017(1)(c), F.S.
Sections 5 through 7 amend ss. 458.316, 458.3165, and 458.317, F.S., to conform cross-references.
Section 8. Provides for an appropriation from the General Revenue Fund and that implementation is contingent upon receiving an appropriation.
Section 9. Provides that the bill will take effect on October 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

According to the Department of Health the fiscal impact reflects costs for compiling and evaluating reports of physician licensure data by specialty and location.

1. Revenues:

   No dedicated source of revenue.

2. Expenditures:

Estimated Expenditures	1st Year	2nd Year (Annualized/Recurr.)
Salaries		
1 FTE Research Associate (no lapse, base + 10% w/28% fringe) - DHAT	$50,340	$50,340
1 part time OPS Admin. Support staff at 25 hours/week @$10.00 hour – DHAT	$13,995	$13,995
1 part time OPS Operations Management Consultant at 25	$23,791	$23,791

hours/week @$17.00 hour -to support desk audit functions - DHAT		
Expense		
DOH Professional Package 1 FTE with limited travel and 1 OPS - DHAT	$23,479	$16,793
DOH Support Staff Package - DHAT	$7,986	$5,195
GIS Mapping Software - DHAT	$10,000	
HR Services (1FTE and 2 part-time OPS) – DHAT	$657	$657
OCO		
Standard OCO professional packages for 1 FTE and 1 OPS - DHAT	$3,800	0
Standard OCO package for 1 support staff – DHAT	$2,100	0
Other		
Software costs (MQA)	$25,000	0
Total Estimated Expenditures	$161,148	$110,771

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Physicians will incur the cost of having their core credentials verified by the Federation of State Medical Boards (FSMB). A one time fee is assessed for this service of approximately $275. Additional fees may be assessed to collect such items as examination transcripts and Educational Commission for Foreign Medical Graduates (ECFMG) Program certification.[1] Physicians, who complete the verification process conducted by the federation, establish a life-long file of their credentials, which can be easily accessed throughout their career by potential employers, state licensure, hospital privileges, and professional memberships. This may also be beneficial for foreign trained physicians who may have difficulty accessing or gathering core credentialing information from the medical school they attended in another country.

D. FISCAL COMMENTS:

According to the Department of Health, the cost to implement the provisions of the bill will be approximately $161,000 for the first year and approximately $110,000 each preceding year.

[1] The Educational Commission for Foreign Medical Graduates (ECFMG) assesses whether international medical graduates met minimum standards of eligibility to include the verification of education. In order for international medical graduates to receive licensure to practice medicine in Florida, applicants must have ECFMG certification.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or take an action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

According to the House General Counsel Office, the bill's reenactment of section 458.347(7)(b), F.S., is not necessary. Reenacting this section was included in the bill as a technicality in order to ensure that the amendment to s. 458.311(1)(g), F.S. is applied.

In determining the Legislature's intention as to whether reenactment of a statute containing a cross-reference to another statute being amended, is required in order that the changes to the statute being amended are incorporated into the statute containing the reference, the general rule is that: [2]

A cross-reference to a general body of law (without reference to a specific statute) incorporates the referenced law and any subsequent amendment to or repeal of the referenced law....

In contrast, as a general rule, a cross-reference to a specific statute incorporates the language of the referenced statute as it existed at the time the reference was enacted, unaffected by any subsequent amendments to or repeal of the incorporated statute.[3]

In *U. S. v. Rodriguez-Rodriguez*, the Court recognized the general rule, but went on to find, however, that "[a] provision which... reads as a specific reference may, in context, be construed as a general reference. In addition, if the legislature expressly or by strong implication shows an intention to incorporate subsequent amendments, such subsequent amendments are to be considered part of a general scheme."[4] Both in *Rodriguez* and *E.E.O.C. v. Chrysler Corp.*[5], the courts found that although there was a specific reference in the form of a statute number, the reference nonetheless should be construed as a general reference.

According to General Counsel, while s. 458.347(b)1.b.(I), F.S., refers to requirements for licensure set forth in s. 458.311(1),F.S., it might just as easily refer to requirements for license set forth in "general law." There is nothing in Florida law to suggest that the particular licensing provisions in s. 458.311(1), F.S., were selected over some other statutory medical licensing requirements. According to General Counsel, this is a general reference posing as a specific one as was the case in E.E.O.C., where the court found that "the complex interplay of two statutory schemes, one of which is incorporated into the other, warrants the conclusion that this facially specific reference actually operates as a general one."[6]

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[2] Florida Statutes, vol. 1, p. viii, Statutory Construction, Cross-references.
[3] Ibid.
[4] *U. S. v. Rodriguez-Rodriguez*, 863 F.2d 830 (11th Cir. 1989), citing 2A Sutherland Statutory Construction § 51.07 at 514 (4th ed. 1984).
[5] *E.E.O.C. v. Chrysler Corp.*, 546 F.Supp. 54, 74 (E.D. Mich. 1982) aff'd 733 F.2d 1183 (6th Cir.1984).
[6] *Id.* at 74.

B. RULE-MAKING AUTHORITY:

No additional rulemaking authority is required to implement the provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

According to the Department of Health, current data sources, particularly the department's MQA licensure data, are not sufficient to prepare a report on the geographic distribution of physicians by specialty. To prepare an annual report to meet the needs of the Graduate Medical Education Committee and the Community Hospital Education Council, the collection of data on physicians in the DOH licensing process must be expanded.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

A bill to be entitled

An act relating to physicians; creating s. 381.0304, F.S.; requiring the Division of Health Access and Tobacco within the Department of Health to monitor, evaluate, and report on the supply and distribution of physicians and osteopathic physicians in the state; amending ss. 458.311 and 458.313, F.S.; requiring applicants for physician licensure to submit core credentials to the Federation of State Medical Boards for verification; reenacting s. 458.347(7)(b), F.S., relating to physician assistants, in order to incorporate the amendment to s. 458.311, F.S., in a reference thereto; amending ss. 458.316, 458.3165, and 458.317, F.S.; conforming cross-references; providing an appropriation; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 381.0304, Florida Statutes, is created to read:

381.0304 Supply and distribution of physicians; reports.--The Division of Health Access and Tobacco of the department shall monitor, evaluate, and report on the supply and distribution of physicians and osteopathic physicians in this state. The division shall develop a strategy to track and analyze, on an ongoing basis, the distribution of state-licensed physicians by specialty and geographic location using data that are available from public and private sources. The division shall submit a report to the Governor, the President of the

Senate, and the Speaker of the House of Representatives by January 1, 2008, and annually thereafter.

Section 2. Subsection (1) of section 458.311, Florida Statutes, is amended to read:

458.311 Licensure by examination; requirements; fees.--

(1) Any person desiring to be licensed as a physician, who does not hold a valid license in any state, shall apply to the department on forms furnished by the department. The department shall license each applicant who the board certifies:

(a) Has completed the application form and remitted a nonrefundable application fee not to exceed $500.

(b) Is at least 21 years of age.

(c) Is of good moral character.

(d) Has not committed any act or offense in this or any other jurisdiction which would constitute the basis for disciplining a physician pursuant to s. 458.331.

(e) For any applicant who has graduated from medical school after October 1, 1992, has completed the equivalent of 2 academic years of preprofessional, postsecondary education, as determined by rule of the board, which shall include, at a minimum, courses in such fields as anatomy, biology, and chemistry prior to entering medical school.

(f) Meets one of the following medical education and postgraduate training requirements:

1.a. Is a graduate of an allopathic medical school or allopathic college recognized and approved by an accrediting agency recognized by the United States Office of Education or is a graduate of an allopathic medical school or allopathic college

within a territorial jurisdiction of the United States recognized by the accrediting agency of the governmental body of that jurisdiction;

b. If the language of instruction of the medical school is other than English, has demonstrated competency in English through presentation of a satisfactory grade on the Test of Spoken English of the Educational Testing Service or a similar test approved by rule of the board; and

c. Has completed an approved residency of at least 1 year.

2.a. Is a graduate of an allopathic foreign medical school registered with the World Health Organization and certified pursuant to s. 458.314 as having met the standards required to accredit medical schools in the United States or reasonably comparable standards;

b. If the language of instruction of the foreign medical school is other than English, has demonstrated competency in English through presentation of the Educational Commission for Foreign Medical Graduates English proficiency certificate or by a satisfactory grade on the Test of Spoken English of the Educational Testing Service or a similar test approved by rule of the board; and

c. Has completed an approved residency of at least 1 year.

3.a. Is a graduate of an allopathic foreign medical school which has not been certified pursuant to s. 458.314;

b. Has had his or her medical credentials evaluated by the Educational Commission for Foreign Medical Graduates, holds an active, valid certificate issued by that commission, and has passed the examination utilized by that commission; and

c. Has completed an approved residency of at least 1 year; however, after October 1, 1992, the applicant shall have completed an approved residency or fellowship of at least 2 years in one specialty area. However, to be acceptable, the fellowship experience and training must be counted toward regular or subspecialty certification by a board recognized and certified by the American Board of Medical Specialties.

(g) Has submitted core credentials to the Federation Credentials Verification Services of the Federation of State Medical Boards for verification.

(h) ~~(g)~~ Has submitted to the department a set of fingerprints on a form and under procedures specified by the department, along with a payment in an amount equal to the costs incurred by the Department of Health for the criminal background check of the applicant.

(i) ~~(h)~~ Has obtained a passing score, as established by rule of the board, on the licensure examination of the United States Medical Licensing Examination (USMLE); or a combination of the United States Medical Licensing Examination (USMLE), the examination of the Federation of State Medical Boards of the United States, Inc. (FLEX), or the examination of the National Board of Medical Examiners up to the year 2000; or for the purpose of examination of any applicant who was licensed on the basis of a state board examination and who is currently licensed in at least one other jurisdiction of the United States or Canada, and who has practiced pursuant to such licensure for a period of at least 10 years, use of the Special Purpose Examination of the Federation of State Medical Boards of the

United States (SPEX) upon receipt of a passing score as established by rule of the board. However, for the purpose of examination of any applicant who was licensed on the basis of a state board examination prior to 1974, who is currently licensed in at least three other jurisdictions of the United States or Canada, and who has practiced pursuant to such licensure for a period of at least 20 years, this paragraph does not apply.

Section 3. Paragraph (a) of subsection (1) of section 458.313, Florida Statutes, is amended to read:

458.313 Licensure by endorsement; requirements; fees.--

(1) The department shall issue a license by endorsement to any applicant who, upon applying to the department on forms furnished by the department and remitting a fee set by the board not to exceed $500, the board certifies:

(a) Has met the qualifications for licensure in s. 458.311(1)(b)-(h) ~~s. 458.311(1)(b)-(g)~~ or in s. 458.311(1)(b)-(e) and (h) ~~(g)~~ and (3);

Section 4. For the purpose of incorporating the amendment made by this act to section 458.311, Florida Statutes, in a reference thereto, and not for the purpose of superseding the provisions of section 456.017(1)(c), Florida Statutes, paragraph (b) of subsection (7) of section 458.347, Florida Statutes, is reenacted to read:

458.347 Physician assistants.--

(7) PHYSICIAN ASSISTANT LICENSURE.--

(b)1. Notwithstanding subparagraph (a)2. and sub-subparagraph (a)3.a., the department shall examine each applicant who the Board of Medicine certifies:

a. Has completed the application form and remitted a nonrefundable application fee not to exceed $500 and an examination fee not to exceed $300, plus the actual cost to the department to provide the examination. The examination fee is refundable if the applicant is found to be ineligible to take the examination. The department shall not require the applicant to pass a separate practical component of the examination. For examinations given after July 1, 1998, competencies measured through practical examinations shall be incorporated into the written examination through a multiple-choice format. The department shall translate the examination into the native language of any applicant who requests and agrees to pay all costs of such translation, provided that the translation request is filed with the board office no later than 9 months before the scheduled examination and the applicant remits translation fees as specified by the department no later than 6 months before the scheduled examination, and provided that the applicant demonstrates to the department the ability to communicate orally in basic English. If the applicant is unable to pay translation costs, the applicant may take the next available examination in English if the applicant submits a request in writing by the application deadline and if the applicant is otherwise eligible under this section. To demonstrate the ability to communicate orally in basic English, a passing score or grade is required, as determined by the department or organization that developed it, on the test for spoken English (TSE) by the Educational Testing Service (ETS), the test of English as a foreign language (TOEFL) by ETS, a high school or college level English course,

or the English examination for citizenship, Bureau of Citizenship and Immigration Services. A notarized copy of an Educational Commission for Foreign Medical Graduates (ECFMG) certificate may also be used to demonstrate the ability to communicate in basic English; and

b.(I) Is an unlicensed physician who graduated from a foreign medical school listed with the World Health Organization who has not previously taken and failed the examination of the National Commission on Certification of Physician Assistants and who has been certified by the Board of Medicine as having met the requirements for licensure as a medical doctor by examination as set forth in s. 458.311(1), (3), (4), and (5), with the exception that the applicant is not required to have completed an approved residency of at least 1 year and the applicant is not required to have passed the licensing examination specified under s. 458.311 or hold a valid, active certificate issued by the Educational Commission for Foreign Medical Graduates; was eligible and made initial application for certification as a physician assistant in this state between July 1, 1990, and June 30, 1991; and was a resident of this state on July 1, 1990, or was licensed or certified in any state in the United States as a physician assistant on July 1, 1990; or

(II) Completed all coursework requirements of the Master of Medical Science Physician Assistant Program offered through the Florida College of Physician's Assistants prior to its closure in August of 1996. Prior to taking the examination, such applicant must successfully complete any clinical rotations that

were not completed under such program prior to its termination and any additional clinical rotations with an appropriate physician assistant preceptor, not to exceed 6 months, that are determined necessary by the council. The boards shall determine, based on recommendations from the council, the facilities under which such incomplete or additional clinical rotations may be completed and shall also determine what constitutes successful completion thereof, provided such requirements are comparable to those established by accredited physician assistant programs. This sub-sub-subparagraph is repealed July 1, 2001.

2. The department may grant temporary licensure to an applicant who meets the requirements of subparagraph 1. Between meetings of the council, the department may grant temporary licensure to practice based on the completion of all temporary licensure requirements. All such administratively issued licenses shall be reviewed and acted on at the next regular meeting of the council. A temporary license expires 30 days after receipt and notice of scores to the licenseholder from the first available examination specified in subparagraph 1. following licensure by the department. An applicant who fails the proficiency examination is no longer temporarily licensed, but may apply for a one-time extension of temporary licensure after reapplying for the next available examination. Extended licensure shall expire upon failure of the licenseholder to sit for the next available examination or upon receipt and notice of scores to the licenseholder from such examination.

3. Notwithstanding any other provision of law, the examination specified pursuant to subparagraph 1. shall be

administered by the department only five times. Applicants certified by the board for examination shall receive at least 6 months' notice of eligibility prior to the administration of the initial examination. Subsequent examinations shall be administered at 1-year intervals following the reporting of the scores of the first and subsequent examinations. For the purposes of this paragraph, the department may develop, contract for the development of, purchase, or approve an examination that adequately measures an applicant's ability to practice with reasonable skill and safety. The minimum passing score on the examination shall be established by the department, with the advice of the board. Those applicants failing to pass that examination or any subsequent examination shall receive notice of the administration of the next examination with the notice of scores following such examination. Any applicant who passes the examination and meets the requirements of this section shall be licensed as a physician assistant with all rights defined thereby.

Section 5. Subsection (1) of section 458.316, Florida Statutes, is amended to read:

458.316 Public health certificate.--

(1) Any person desiring to obtain a public health certificate shall submit an application fee not to exceed $300 and shall demonstrate to the board that he or she is a graduate of an accredited medical school and holds a master of public health degree or is board eligible or certified in public health or preventive medicine, or is licensed to practice medicine without restriction in another jurisdiction in the United States

and holds a master of public health degree or is board eligible or certified in public health or preventive medicine, and shall meet the requirements in s. 458.311(1)(a)-(f) and (h) ~~s. 458.311(1)(a)-(g)~~ and (5).

Section 6. Section 458.3165, Florida Statutes, is amended to read:

458.3165 Public psychiatry certificate.--The board shall issue a public psychiatry certificate to an individual who remits an application fee not to exceed $300, as set by the board, who is a board-certified psychiatrist, who is licensed to practice medicine without restriction in another state, and who meets the requirements in s. 458.311(1)(a)-(f) and (h) ~~s. 458.311(1)(a)-(g)~~ and (5). A recipient of a public psychiatry certificate may use the certificate to work at any public mental health facility or program funded in part or entirely by state funds.

(1) Such certificate shall:

(a) Authorize the holder to practice only in a public mental health facility or program funded in part or entirely by state funds.

(b) Be issued and renewable biennially if the secretary of the Department of Health and the chair of the department of psychiatry at one of the public medical schools or the chair of the department of psychiatry at the accredited medical school at the University of Miami recommend in writing that the certificate be issued or renewed.

(c) Automatically expire if the holder's relationship with a public mental health facility or program expires.

(d) Not be issued to a person who has been adjudged unqualified or guilty of any of the prohibited acts in this chapter.

(2) The board may take disciplinary action against a certificateholder for noncompliance with any part of this section or for any reason for which a regular licensee may be subject to discipline.

Section 7. Paragraph (a) of subsection (1) of section 458.317, Florida Statutes, is amended to read:

458.317 Limited licenses.--

(1)

(a) Any person desiring to obtain a limited license shall:

1. Submit to the board, with an application and fee not to exceed $300, an affidavit stating that he or she has been licensed to practice medicine in any jurisdiction in the United States for at least 10 years and intends to practice only pursuant to the restrictions of a limited license granted pursuant to this section. However, a physician who is not fully retired in all jurisdictions may use a limited license only for noncompensated practice. If the person applying for a limited license submits a notarized statement from the employing agency or institution stating that he or she will not receive compensation for any service involving the practice of medicine, the application fee and all licensure fees shall be waived. However, any person who receives a waiver of fees for a limited license shall pay such fees if the person receives compensation for the practice of medicine.

2. Meet the requirements in s. 458.311(1)(b)-(f) and (h)

~~s. 458.311(1)(b)-(g)~~ and (5). If the applicant graduated from medical school prior to 1946, the board or its appropriate committee may accept military medical training or medical experience as a substitute for the approved 1-year residency requirement in s. 458.311(1)(f).

Nothing herein limits in any way any policy by the board, otherwise authorized by law, to grant licenses to physicians duly licensed in other states under conditions less restrictive than the requirements of this section. Notwithstanding the other provisions of this section, the board may refuse to authorize a physician otherwise qualified to practice in the employ of any agency or institution otherwise qualified if the agency or institution has caused or permitted violations of the provisions of this chapter which it knew or should have known were occurring.

Section 8. The sum of $ is appropriated from the General Revenue Fund to the Department of Health for implementing this act during the 2006-2007 fiscal year. This act shall be implemented contingent on an appropriation in the General Appropriations Act.

Section 9. This act shall take effect October 1, 2006.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1157 Dental Charting
SPONSOR(S): Mayfield
TIED BILLS: **IDEN./SIM. BILLS:** SB 2178

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee		Hamrick	Mitchell
2) Health Care Appropriations Committee			
3) Health & Families Council			
4)			
5)			

SUMMARY ANALYSIS

HB 1157 expands the scope of practice for dental hygienists to enable them to perform dental charting without supervision by a dentist in locations such as public educational institutions, nursing homes, community health centers, and health fairs with certain limitations. Dental charting is the recording of visual observations of clinical conditions of the mouth such as missing teeth and restorations.

The bill does not appear to have a fiscal impact on state or local governments.

The bill will take effect on July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government and personal responsibility-The bill allows dental hygienists to perform dental charting without supervision by a dentist in locations such as public educational institutions, nursing homes, community health centers, and health fairs.

B. EFFECT OF PROPOSED CHANGES:

The bill expands the scope of practice of dental hygienists by allowing them to perform the task of dental charting without supervision of a dentist. The bill provides that dental charting is the recording of visual observations of clinical conditions of the mouth. Visual observations are done without the use of such diagnostic tools as x-rays or laboratory tests. The bill provides that a dental hygienist may only use instruments that are necessary to look at missing teeth, restorations, suspicious areas, and periodontal pockets.

The bill provides that dental charting may be performed in public and private educational institutions of the state and Federal Government, nursing homes, assisted living and long-term care facilities, community health centers, health fairs, and mobile dental or health units.

A person who receives dental charting must review and sign a written disclosure form. The disclosure form must state that the purpose of the dental charting is to collect data for use by a dentist at a prompt subsequent examination and that the diagnosis of cavities, soft tissue disease, oral cancer, and certain other conditions may only be done by a dentist during a comprehensive examination.

The bill requires that the Board of Dentistry approve the content of the disclosure and dental charting forms. Both forms must emphasize the limitation of dental charting and encourage a complete dental examination to assess a persons overall oral health.

The bill places restrictions on direct reimbursement and patient referrals which require compliance with anti-kickback and patient brokering laws. The bill also stipulates that performing dental charting does not create a patient of record or a medical record.

PRESENT SITUATION

According to the Children's Dental Health Project (CDHP), tooth decay is the single most common chronic disease of childhood. Without access to regular preventative dental services, dental care for many children is postponed until symptoms become so acute that care is sought in hospital emergency departments.[1] According to the CDHP, more than 51 million school hours are lost each year to dental-related illness and 25 percent of children living in poverty have not seen a dentist prior to entering kindergarten.[2]

A report by the Surgeon General found that people 55 to 74 years of age have higher rates of periodontal disease and also have an increasing amount of tooth decay compared to younger adults. The elderly's use of dental care can be substantially influenced by financial barriers and other nondental health concerns.[3]

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[1] Children's Dental Health Project. 2005. A Policy Brief: Cost Effectiveness of Preventative Dental Services.
[2] Children's Dental Health Project. 2002. Children's Dental Health Needs and School-Based Services: A Fact Sheet.
[3] The United States Department of Health and Human Services. 2000. Oral health in America: a report of the Surgeon General.

Dental Hygienists Current Scope of Practice

Section 466.024, F.S., provides that dental hygienists may remove calculus deposits, accretions, and stains from exposed surfaces of the teeth and shallow grooves or depressions of the gums. They may use metal scalers to perform deep teeth cleaning which involves the removal of hard deposits, below the gumline. They may also use a spoon-shaped instrument called curettage, to scrape tissue from a cavity.

Dental hygienists may expose dental X-ray films, apply topical preventive or prophylactic agents, and perform tasks delegated by a supervising dentist.

Currently, a dental hygienist may work in an office of a licensed dentist, in public health programs and institutions of the Department of Children and Family Services, Department of Health, and Department of Juvenile Justice under the general supervision of a licensed dentist.

A dental hygienist may work in other settings, if a patient presents a valid prescription from a dentist that is not older than two years. Such settings include:

- Licensed public and private health facilities;
- Other public institutions of the state and federal government;
- Public and private educational institutions; and
- The home of a non-ambulatory patient.

In this situation, the dentist issuing a prescription for dental hygiene care remains responsible for the care the patient.

Dental hygienists may, without supervision, provide educational programs, faculty or staff training programs, authorized fluoride rinse programs, and other services which do not involve diagnosis or treatment of dental conditions and which services are approved by the Board of Dentistry.

C. SECTION DIRECTORY:

Section 1. Amends s. 466.023, F.S., to provide that a dental hygienist may perform dental charting without supervision.
Section 2. Creates s. 466.0235, F.S., to provide a definition of dental charting; locations where dental charting may occur; a written disclosure that must be signed when dental charting occurs; require board approval of the content of the disclosure and dental charting form; place restrictions on direct reimbursement, and patient referrals; and establish that the use of a dental charting form does not constitute the creation of a patient of record or a medical record.
Section 3. Provides that the bill will take effect on July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Dental charting performed by dental hygienists may provide access to needed dental services, specifically preventative oral health screenings, by low income children and adults. The screenings may encourage individuals to have a comprehensive dental examination done. Failure to prevent dental problems may have adverse long-term effects, which may be costly.

D. FISCAL COMMENTS:

According to the Department of Health, there will be a minimal fiscal impact for rule promulgation which can be covered with existing resources.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or take an action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill provides that the board must approve the content of a disclosure and a dental charting form. According to the Department of Health, the bill does not explicitly require the board to engage in rulemaking. Due to the lack of clarity and implication, more specific rule-making authorization would be beneficial.

C. DRAFTING ISSUES OR OTHER COMMENTS:

DRAFTING ISSUES:
The bill provides on lines 37-38, that a dental hygienist may perform dental charting in "...public and private educational institutions of the state and federal government." This is problematic since there are not any "private educational institutions of the state and federal government."

It would be beneficial to provide rule-making authority to the Board of Dentistry to approve the content of the disclosure and dental charting forms.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

A bill to be entitled

An act relating to dental charting; amending s. 466.023, F.S.; expanding the scope and area of practice of dental hygienists to include dental charting; creating s. 466.0235, F.S.; providing for regulation of dental charting; providing a definition; authorizing dental hygienists to perform dental charting under certain conditions; regulating the use and content of disclosure and charting forms; requiring the Board of Dentistry to approve disclosure and charting forms; limiting the applicability of dental charting; providing restrictions on dental charting reimbursement, referrals made in conjunction with the provision of dental charting services, and the provision of dental charting by a dental hygienist without supervision; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (5) of section 466.023, Florida Statutes, is renumbered as subsection (6), and a new subsection (5) is added to that section to read:

466.023 Dental hygienists; scope and area of practice.--

(5) Dental hygienists may, without supervision, perform dental charting as provided in s. 466.0235.

Section 2. Section 466.0235, Florida Statutes, is created to read:

466.0235 Dental charting.--

(1) For purposes of this section, the term "dental charting" means a recording of visual observations of clinical conditions of the oral cavity without the use of X rays, laboratory tests, or other diagnostic methods or equipment, except the instruments necessary to record visual restorations, missing teeth, suspicious areas, and periodontal pockets.

(2) A dental hygienist may, without supervision and within the lawful scope of his or her duties as authorized by law, perform dental charting of hard and soft tissues in public and private educational institutions of the state and Federal Government, nursing homes, assisted living and long-term care facilities, community health centers, and mobile dental or health units. A dental hygienist may also perform dental charting on a volunteer basis at health fairs.

(3) Each person who receives a dental charting pursuant to this section, or the parent or legal guardian of the person, shall receive and sign a written disclosure form before receiving the dental charting procedure that states that the purpose of the dental charting is to collect data for use by a dentist at a prompt subsequent examination. The disclosure form shall also emphasize that diagnosis of caries, soft tissue disease, oral cancer, temporomandibular joint disease (TMJ), and dentofacial malocclusions can only be completed by a dentist in the context of delivering a comprehensive dental examination.

(4) The board shall approve the content of charting and disclosure forms to be used under this section. Both forms shall emphasize the inherent limitations of dental charting and encourage complete examination by a dentist in rendering a

professional diagnosis of the patient's overall oral health needs.

(5) Dental charting performed under this section is not a substitute for a comprehensive dental examination.

(6) Nothing in this section shall be construed to permit direct reimbursement for dental charting performed under this section by Medicaid, health insurers, health maintenance organizations, prepaid dental plans, or other third-party payors beyond what is otherwise allowable by law.

(7) All referrals made in conjunction with the provision of dental charting services under this section shall be in strict conformance with federal and state patient referral, anti-kickback, and patient brokering laws.

(8) A dental hygienist performing dental charting without supervision shall not be deemed to have created either a patient of record or a medical record.

Section 3. This act shall take effect July 1, 2006.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1293 Medical Malpractice Insurance
SPONSOR(S): Grant
TIED BILLS: **IDEN./SIM. BILLS:** SB 2160

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee		Bell	Mitchell
2) Health & Families Council			
3)			
4)			
5)			

SUMMARY ANALYSIS

HB 1293 creates ss. 766.401-766.406, F.S., to provide incentives for statutory teaching hospitals to implement hospital-wide patient safety programs and to address the issue of medical malpractice.

The bill specifies the six statutory teaching hospitals in the state as eligible to participate in the Patient Safety and Provider Liability Act. The hospitals targeted in the bill are: Jackson Memorial Hospital, Tampa General Hospital, Shands at the University of Florida, Shands Jacksonville, Orlando Regional Medical Center, and Mount Sinai Medical Center.

The bill encourages and provides incentives for the eligible hospitals to create a patient safety plan that includes an array of patient safety protection measures that are described in s. 766.403, F.S, created in the bill. Some of the incentives include participation in the Florida Patient Safety Corporation's "near miss" reporting system and implementation of a simulation-based program for skills assessment, training, and retraining of facility staff. Patient safety plans would be reviewed and certified by the Agency for Health Care Administration.

A hospital that obtains certification from AHCA would qualify for a $500,000 limit on noneconomic damages in medical malpractice actions, and periodic payments of economic damages.

The bill also clarifies that *any* hospital may extend insurance or self-insurance coverage to members of its medical staff.

It is unclear how many eligible hospitals would submit a patient safety plan to be certified by the Agency for Health Care Administration (AHCA). AHCA may incur a cost to certify patient safety plans created in the bill. AHCA did not provide the Health Care Regulation Committee with an estimated fiscal impact.

The effective date of the bill is upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government – The bill creates parameters for patient safety plans. Eligible hospitals would be required to get their plans certified by the Agency for Health Care Administration (AHCA). Eligible hospitals with certified patient safety plans would qualify for a $500,000 cap on noneconomic damages arising from medical malpractice and periodic payments of economic damages.

Empower Families – The patient safety plan requirements are likely to improve the quality of care for patients in certified patient safety facilities.

B. EFFECT OF PROPOSED CHANGES:

Overview

The bill creates ss. 766.401-766.406, F.S., to provide incentives for statutory teaching hospitals to implement hospital-wide patient safety programs and to address the issue of medical malpractice.

The bill creates an unnumbered section to designate a short title and provide legislative findings. The short title is, "Patient Safety and Provider Liability Act."

The bill specifies the six statutory teaching hospitals in the state as eligible to participate in the Patient Safety and Provider Liability Act. The hospitals are: Jackson Memorial Hospital, Tampa General Hospital, Shands at the University of Florida, Shands Jacksonville, Orlando Regional Medical Center, and Mount Sinai Medical Center.

The bill encourages and provides incentives for the eligible hospitals to create a patient safety plan that includes an array of patient safety protection measures that are described in s. 766.403, F.S, created in the bill.

Patient safety plans are reviewed and certified by the Agency for Health Care Administration (AHCA). Plans must satisfy all the requirements created in ss. 766.401-766.405, F.S. The patient safety provisions include: participation in the Florida Patient Safety Corporation's "near miss" reporting system, implementation of an early intervention program that provides additional skill training, and a simulation program for skills assessment, training, and staff retraining.

An eligible hospital that obtains certification from AHCA that its patient safety plan meets the requirements qualifies for a $500,000 limit on noneconomic damages in medical malpractice actions and may make periodic payments of economic damages.

The bill amends s. 766.110, F.S. to clarify that any hospital may extend insurance or self-insurance coverage to members of its medical staff.

The effective date of the bill is upon becoming law.

Patient Safety Certification

The bill provides incentives for statutory teaching hospitals to seek designation as a certified patient safety facility by submitting a petition to the Agency for Health Care Administration (AHCA). The petition would seek an AHCA order approving the facility's patient safety plan. The order would remain in effect until revoked the by AHCA. The bill requires hospitals with certified patient safety plans to submit an annual report to AHCA.

Patient Safety Requirements

A patient safety plan must include several comprehensive patient safety measures and procedures. In order for a statutory teaching hospital to qualify for the $500,000 cap on noneconomic damages and periodic payments of economic damages, an eligible hospital's patient safety plans must:

- Have in place a process for coordinating the quality control, risk management, and patient-relations functions of the facility and for reporting to the facility's governing board at least quarterly regarding such efforts;
- Establish within the facility a system for reporting near misses and agree to submit any information collected to the Florida Patient Safety Corporation (FPSC);
- Design and make available to facility staff a patient-safety curriculum that provides lectures and web-based training on recognized patient-safety principles. It may include training in communication skills, team-performance assessment and training, risk-prevention strategies, and best practice and evidenced based medicine. The licensed facility shall report annually to AHCA;
- Implement a program to identify health care providers on the facility's staff who may be eligible for an early intervention program that provides additional skills for assessment and training and offer such training to the staff on a voluntary and confidential basis with established mechanisms to assess program performance and results;
- Implement a simulation-based program for skills assessment, training, and retraining of a facility's staff in those tasks and activities that AHCA identifies by rule;
- Designate a patient advocate who coordinates with members of the medical staff and the facility's chief medical officer regarding the disclosure of adverse medical incidents to patients. In addition, the patient advocate shall establish an advisory panel, consisting of providers, patients and their families, and other health care consumers or consumer groups to review general patient-safety concerns and other issues related to relations among and between patients and providers and to identify areas where additional education and program development may be appropriate;
- Establish procedures to biennially review the facility's patient-safety program and its compliance with s. 766.402, F.S. Such review shall be conducted by an independent patient-safety organization as defined by s. 766.1016(1), F.S., or other professional organization approved by AHCA. The organization performing the review shall prepare a written report that contains detailed findings and recommendations. The report shall be forwarded to the facility's risk manager or patient-safety officer, who may make written comments in response. The report and any written comments shall be presented to the governing board of the licensed facility. A copy of the report and any of the facility's responses to the findings and recommendations shall be provided to AHCA within 60 days after the date that the governing board reviewed the report.; and
- Establish a system for trending and tracking of quality patient-safety indicators that AHCA may identify by rule, and a method for review of the data at least semiannually by the facility's patient-safety committee.

Limits on Nonecomonic Damages

In exchange for the patient safety provisions included in the statutory teaching hospital's patient safety plans, eligible hospitals will have a $500,000 limit on noneconomic damages in medical malpractice actions, regardless of number of claimants, number of claims, or theory of liability, including vicarious liability, arising from the same nucleus of operative fact.

Periodic Payments of Economic Damages

Another benefit of compliance with the patient safety plan requirements, is that teaching hospitals will be permitted to make periodic payment of future economic damages. This will provide for the payment of damages over time, rather than lump-sum payments.

The bill requires periodic payments to be paid through an annuity or a reversionary trust. The annuity underwriting company must have a rating of "A" or higher by A.M. Best Company.

Legislative Findings

The bill provides legislative findings and intent related to medical education in Florida, patient safety, medical malpractice, and statutory teaching hospitals. The bill makes the following legislative findings:

- This state is in the midst of a prolonged medial malpractice insurance crisis that has serious adverse effects on patients, practitioners, licensed health care facilities, and all residents of this state.
- Hospitals are central components of the modern health care delivery system.
- The medical malpractice insurance crisis in this state can be alleviated through the adoption of innovative approaches for patient safety in teaching hospitals, which can lead to a reduction in medical errors coupled with a limitation on noneconomic damages that can be awarded against a teaching hospital that implements such innovative approaches.
- Statutory incentives are necessary to facilitate innovative approaches for patient safety in hospitals and that such incentives and patient-safety measures will benefit all persons seeking health care services in this state.
- Coupling patient safety measures with a limitation on provider liability in teaching hospitals will lead to a reduction in the frequency and severity of incidents of medical malpractice in hospitals.
- A reduction in the frequency and severity of incidents of medical malpractice in hospitals will reduce attorney's fees and other expenses inherent in the medical liability system.
- There is no alternative method that addresses the overwhelming public necessity to implement patient-safety measures and limit provider liability.
- Making high-quality health care available to the residents of this state is an overwhelming public necessity.
- Medical education in this state is an overwhelming public necessity.
- Statutory teaching hospitals are essential for high-quality medical care and medical education in this state.
- The critical mission of statutory teaching hospitals is severely undermined by the ongoing medical malpractice crisis.
- Teaching hospitals are appropriate health care facilities for the implementation of innovative approaches to enhancing patient safety and limiting provider liability.
- There is an overwhelming public necessity to impose reasonable limitations on actions for medical malpractice against teaching hospitals in furtherance of the critical public interest in promoting access to high-quality medical care, medical education, and innovative approaches to patient safety and provider liability.
- There is an overwhelming public necessity for teaching hospitals to implement innovative measures for patient safety and limit provider liability in order to generate empirical data for state policymakers concerning the effectiveness of these measures. Such data may lead to broader application of these measures in a wider array of hospitals after a reasonable period of evaluation and review.
- There is an overwhelming public necessity to promote the academic mission of teaching hospitals. Furthermore, the Legislature finds that the academic mission of these medical facilities is materially enhanced by statutory authority for the implementation of innovative approaches to promoting patient safety and limiting provider liability. Such approaches can be carefully studied and learned by medical students, medical school faculty, and affiliated physicians in appropriate clinical settings, thereby enlarging the body of knowledge concerning patient safety and provider liability which is essential for advancement of patient safety, reduction of expenses inherent in the medical insurance crisis in this state.

CURRENT SITUATION

Patient Safety Requirements

Currently hospitals are required to have a number of patient safety provisions. Section 395.1012, F.S. requires all hospitals to adopt a patient safety plan, a patient safety officer, and a patient safety committee. The various structures hospitals have developed to meet this requirement vary in composition and quality.

As part of the health care practitioner general licensing provisions in s. 456.013, F.S., health care practitioners are required to take a 2-hour course relating to prevention of medical errors as part of the licensure and biennial renewal process.

As part of licensure, hospitals are required in s. 395.0197, F.S., to have an internal risk management program. The internal risk management program requires hospitals and physicians to disclose adverse incidents to patients. The Agency for Health Care Administration (AHCA) collects data on certain adverse incidents. These reports are known as "code 15" reports. Hospitals must report to AHCA within 15 days:

- The death of a patient;
- Brain or spinal damage to a patient;
- The performance of a surgical procedure on the wrong patient;
- The performance of a wrong surgical procedure;
- The performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition;
- The surgical repair of damage resulting to a patient from a planned surgical procedure; and
- The performance of procedures to remove unplanned foreign objects remaining from a surgical procedure.

There are currently no requirements for any hospital to participate in the Florida Patient Safety Corporation (FPSC) "near miss" reporting system. Near miss reporting is important to patient safety because if researchers can understand how near errors were averted they can prevent future errors.

Medical Malpractice Caps on Noneconomic Damages

In 2003, the Legislature adopted several medical malpractice reforms, including caps on noneconomic damages in an action for personal injury or wrongful death arising from medical negligence by a practitioner or nonpractitioner:

- For an injury other than a permanent vegetative state or death, noneconomic damages are capped at $500,000 from each practitioner defendant and $750,000 from a nonpractitioner defendant. However, no more than $1 million and $1.5 million can be recovered from all practitioner defendants and all nonpractitioner defendants, respectively, regardless of the number of claimants. Alternatively, the $500,000 cap and $750,000 cap can be "pierced" to allow an injured patient to recover up to $1 million and $1.5 million aggregated from all practitioner defendants and all nonpractitioner defendants, respectively, if the injury qualifies as a catastrophic injury and manifest injustice would occur if the cap was not pierced.
- For an injury that is a permanent vegetative state or death, noneconomic damages are capped at $1 million and $1.5 million from practitioner defendants and nonpractitioner defendants, respectively, regardless of the number of claimants.
- For any type of injury resulting when a practitioner provides emergency services in a hospital or life support services including transportation, provided there is no pre-existing health care patient-practitioner relationship, noneconomic damages are capped at $150,000 per claimant but cannot exceed $300,000, regardless of the number of claimants or practitioner defendants. This cap only applies to injuries prior to the patient being stabilized.

- For any type of injury resulting when a nonpractitioner provides emergency services in a hospital or prehospital emergency treatment pursuant to statutory obligations, provided there is no pre-existing health care patient-practitioner relationship, noneconomic damages are capped at $750,000 per claimant from all nonpractitioner defendants but cannot exceed $1.5 million, regardless of the number of claimants or nonpractitioner defendants.

Periodic Payment of Economic Damages

Periodic payments for the purposes of medical malpractice claims are allowed in section 766.202, F.S. The section authorizes the payment of an award of future economic damages through structured payments over a period of time.

"Periodic payment" is defined to mean provision for the spreading of future economic damage payments, in whole or in part, over a period of time, as follows:

- A specific finding of the dollar amount of periodic payment which will compensate for future damages after offset by collateral sources must be made;
- The defendant must post a bond or security to assure full payment of these damages awarded. The bond must be written by a company that is rated A+ by Bests. If the defendant is unable to adequately assure full payment of the damages, all damages reduced to present value shall be paid to the claimant; and
- The provision for payment of future damages must specify the recipient or recipients of payments.

The Governor's Self Task Force on Healthcare Professional Liability Insurance recommended that the Legislature should amend the Florida Statutes to allow the periodic payment of future noneconomic damages and the Legislature should amend the Florida Statutes to terminate the payment of future economic and noneconomic damages upon the death of the plantiff.

The courts have upheld the use of annuities to cover future payments in medical malpractice judgments in *St. Mary's Hospitals, Inc. v. Phillipe*[1] and *Tallahassee Memorial Regional Medical Center, Inc. v Kinsey*[2].

Hospitals Insuring Medical Staff

Section 766.110, F.S., currently authorizes hospitals to extend insurance coverage to their medical staff. Hospitals must charge their staff a fair market rate for the insurance provided. The bill clarifies that if a hospital self-insures, it may extend its self insurance to its medical staff.

BACKGROUND

The Florida Patient Safety Corporation

The Florida Patient Safety Corporation (FPSC) was created as part of the medical malpractice legislation passed after many special sessions in 2002 and was established by the Legislature in 2004. HB 1629 created the Corporation, under s. 381.0271, F.S.

The FPSC does not regulate health care providers in the state. The FPSC is intended to serve as a learning organization, assist health care providers to improve the quality and safety of health care, reduce harm to patients, and work with a consortium of patient safety centers and other patient safety programs within the state.

[1] 699 So.2d 1017 (Fla. 1st DCA 1997), reh'g denied (Oct. 22, 1997)
[2] 655 So.2d 1191 (Fla. 1st DCA 1995), reh'g denied (June 21, 1995), review denied, 622 So. 2d 344

Only a handful of states have taken the initiative to establish patient safety organizations. Florida has the most comprehensive patient safety mandate. The Legislature mandated a long list of important tasks for the FPSC. House Health Care Regulation Committee staff has monitored the development of the FPSC by attending Board meetings, participating in conference calls, and attending select advisory meetings.

As demonstrated in their yearly Progress Report published December 1, 2005, the FPSC is moving ahead on nearly all of its mandates. One of the key duties the FPSC is charged with is creating a medical error, near miss reporting system. Near miss reporting is essential to patient safety because if researchers can understand how near errors were averted they can prevent future errors. Part of medical error prevention involves looking into medical errors and "near misses" to find the root cause of the errors. The near miss data reporting system is being developed in coordination with the University of Miami/JMH Center for Patient Safety, Marsh/STARS, and CRG Medical. The near miss reporting system will have the following characteristics:

- Reporting will be voluntary, anonymous and independent of mandatory reporting systems used for regulatory purposes;
- Reports of near miss data will be published regularly;
- Special alerts will be published regarding newly identified significant risks;
- Aggregated data will be made publicly available; and
- The FPSC will report the performance and result of the near miss project in its annual report.

The FPSC expects to go live with the near miss reporting system in March 2006 and is currently recruiting hospitals to participate.

Spotlight Patient Safety: The Institute of Medicine, *To Err is Human* Report

Since the National Institute of Medicine (IOM) released *To Err is Human: Building a Safety Health System*[3] in 1999, the nation has been trying to make the institution of medicine safer. The IOM report concluded that as many as 44,000 to 98,000 people die in hospitals each year as the result of medical errors. Medical errors result in more deaths than breast cancer, AIDS, or car accidents. Further, the report concluded that 1 in 25 hospital patients are injured by medical errors. These errors come at a large cost to society. IOM estimates that medical errors cost approximately $37.6 billion each year and that about $17 to $29 billion of the costs are associated with preventable errors.[4]

The IOM report in 1999 brought patient safety into the political spotlight. The federal government, provider organizations, purchasers, and consumers are all focused on the issue. The states, with their responsibility to protect public health and safety, addressed patient safety in a number of ways. The National Academy for State Health Policy (NASHP) reports that initially States concentrated on the idea of mandatory adverse incident reporting. More recently, states have been moving towards a systems approach to patient safety. States recognize that in order to improve the safety of the health care system, they must collaborate with providers, consumers, and purchasers; provide leadership to establish clear goals; develop useful benchmarks to measure progress; and coordinate across all agencies of state government to achieve desired outcomes.[5]

A Systems Problem: Most Medical Errors Preventable

The IOM emphasized that most of the medical errors are systems related and not attributable to individual negligence or misconduct. The key to reducing medical errors is to focus on improving the systems of delivery of care and not to blame individuals. Health care professionals are human and, consequently, they

[3]Institute of Medicine, To Err is Human: Building a Safer Health System, Institute of Medicine, (Washington, D.C.: National Academy Press 1999).
[4] Berntsen, K.J., "How Far Has Healthcare Come since, To Err is Human?" Journal of Nurse Care Quality 19 (2004): 5-7.
[5] Rosenthal, J. & Booth, M., "The Flood Tide Forum – State Patient Safety Centers: A new approach to promote patient safety," National Institute on State Health Policy (2004).

make mistakes. But research has shown that system improvements can substantially reduce the error rates and improve the quality of health care.

The Case for Patient Safety Incentives

There is widespread agreement that the health care system is broken. Costs are rising and there are deficiencies in quality of care and reliability of care. Incentives are one of the techniques recommended by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Centers for Medicare and Medicaid Services (CMS) to create systems change. Financial incentives are one of the most powerful tools for bringing about behavioral change.[6] Re-aligning the financial incentives at the heart of our current health care system to focus on quality of care, safety, and outcomes is long over due.

Currently, provider reimbursement depends less on the quality of care and resulting health outcomes, and more on the intensity and frequency of services delivered. Florida Statutes provide for incentives as, "a mechanism for recognizing the achievement of performance standards or for motivating performance that exceeds performance standards (s. 216.011, F.S.).

Ideally, realignment of incentives can benefit all stakeholders. Payers, including employers and health plans, can benefit from reduced direct costs due to improved care and outcomes. Employers also can benefit from indirect cost reductions due to increased on-the-job productivity and reduced absenteeism through workers receiving better care. Physicians and hospitals can gain financial rewards and the benefits of increased visibility and recognition for performance excellence and potentially reduce malpractice claims. Finally, consumers can gain from greater choice and access to higher quality of care.[7]

The most popular incentive programs offer financial rewards to increase quality, manage costs, increase patient satisfaction, or invest in and implement technology. Although most incentives are monetary, programs may utilize a combination of financial and non-financial rewards.

Florida Statutory Teaching Hospitals

The incentives created by the bill are only eligible to statutory teaching hospitals. There are currently six major teaching hospitals. They include:

- University Medical Center (UMC) in Jacksonville, affiliated with the University of Florida;
- Mount Sinai Hospital (MSH) in Dade County, affiliated with the University of Miami;
- Jackson Memorial (JM)[8] in Dade County, affiliated with the University of Miami;
- Shands Teaching Hospital in Gainesville, affiliated with University of Florida;
- Tampa General (TG), affiliated with University of South Florida; and
- Orlando Regional Medical Center (ORMC), affiliated with the University of Florida.

One of the primary missions of the six Florida teaching hospitals is to train interning physicians and a second is to provide primary sites of care for Florida's indigent population. Each teaching facility receives public subsidies (taxes, grants, and other public revenue) to assist with financing these missions. The range of indigent care and therefore public subsidy support (and operational losses) varies widely.

The six major teaching hospitals account for 80 percent of all graduate medical education (i.e., medical residents), 50 percent of all indigent care, and 30 percent of all Medicaid treatment in Florida. Everyday, Florida's statutory teaching hospitals deliver high quality tertiary health care services to thousands of needy

[6] "Principles for the Construct of Pay-For-Performance Programs," Joint Commission on Accreditation of Healthcare Organizations (2005) Online at: [www.jcaho.org].
[7] Conklin, J., & Weiss, A., "Pay-for-performance: Assembling the building blocks of a sustainable program," Thomson Medstat, Online at: [www.medstat.com].
[8] Jackson Memorial currently has sovereign immunity.

patients. These patients often present themselves with advanced disease and are therefore at higher risk for poor health outcomes.[9]

Kluger Test for Limitations on Access to Courts

Kluger v. White, 281 So.2d 1 (Fla. 1973) established the general proposition that the Legislature may abridge a common law right to recover damages in a civil action (without offending Florida's constitutional right of access to courts) upon a showing of "commensurate benefit" to potential claimants or "an overwhelming public necessity" and proof of "no alternative" for the legislative enactment.

The first prong of the *Kluger* test has been used to sustain the constitutionality of statutory limitations on damages for personal injury in certain automobile accidents, industrial accidents, and birth related neurological injuries.

The second prong of *Kluger* has been used to uphold the constitutionality of legislation providing for a contingent cap on noneconomic damages tied to an early resolution scheme in medical malpractice cases.[10]

Recent Nationwide limits on Medical Malpractice

Medical malpractice tort law has always been maintained at the state level. All states have at least some laws governing medical liability lawsuits. The vast majority of states have statutes of limitation of two years for standard medical malpractice claims. Over half of the states have limits on damages awards. Almost all states have eliminated joint and several liability in malpractice lawsuits, and many states have established limits on attorney fees.

In 2005 alone, 48 state legislatures responded to calls for medical liability reform through the introduction of some 400 bills to address the situation. Solutions ranged from enacting limits on noneconomic damages, to malpractice insurance reform, to gathering lawsuit claim data from malpractice insurance companies and the courts for the purpose of assessing the connection between malpractice settlements and premium rates. During the 2005 legislative session, 32 states enacted over 60 bills, and 2 more states had Supreme Court rulings relating to medical liability lawsuit statutes. Some states chose to enact a number of reforms within one bill; other states enacted a number of bills, each addressing one or two points of medical liability reform. The solutions proposed and variety of aspects addressed in the state legislation demonstrate the diversity of the problem of medical liability insurance costs from state to state. 2003 and 2004 also saw discussion and debate in the state legislatures as they progressed through concerns on medical liability costs.[11]

C. SECTION DIRECTORY:

Section 1. – Creates the short title, "Patient Safety and Provider Liability Act."

Section 2. – Provides legislative findings relating to medical malpractice insurance, role of hospitals, statutory teaching hospitals, and patient safety.

Section 3. – Creates s. 627.41485, F.S., to authorize insurance carriers to issue professional liability coverage for a physician that specifically excludes coverage for claims related to acts of medical negligence occurring within the hospital.

Section 4. – Amends s. 766.110, F.S., to allow hospitals to extend insurance or self-insurance to their medical staff.

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[9] Information supplied by the University of Miami, 2005.
[10] *University of Miami v. Echarte,* 618 So.2d 189
[11] National Conference of State Legislatures, Medical Malpractice Tort Reform, 2006.

Section 5. – Amends s. 766.118, F.S., to provide a $500,000 cap on medical malpractice noneconomic damages for qualifying statutory teaching hospitals.

Section 6. – Creates s. 766.401, F.S., to provide definitions.

Section 7. – Creates s. 766.402, F.S., to provide for the Agency for Health Care Administration to approve statutory teaching hospital patient-safety plans.

Section 8. – Creates s. 766.403, F.S., to provide standards for patient safety plans.

Section 9. – Creates s. 766.404, F.S., to direct each certificated patient-safety facility to submit an annual report to the Agency for Health Care Administration.

Section 10. – Creates s. 766.405, F.S., to allow for economic damages awarded in a medical malpractice case to be paid through periodic payments in the form of an annuity or a reversionary trust.

Section 11. – Creates s. 766.406, F.S., to give AHCA rulemaking authority to administer ss. 766.401-766.405, F.S.

Section 12. – Provides that the provisions of this act are severable.

Section 13. – Provides that this act shall govern in the instance of conflicts with professional licensing statutes.

Section 14. – States that the Legislature intends that the provisions of this act are self-executing.

Section 15. – Provides that this act shall take effect upon becoming law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   Indeterminate.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

It is unclear how many eligible hospitals would submit a patient safety plan to be certified by the Agency for Health Care Administration (AHCA). AHCA may incur a cost to certify patient safety plans

created in the bill. AHCA did not provide the Health Care Regulation Committee with an estimated fiscal impact.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds. This bill does not reduce the percentage of state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

Article I, section 21, of the Florida Constitution, guarantees access to courts, providing as follows:

> The courts shall be open to every person for redress of any injury, and justice shall be administered without sale, denial or delay.

The Florida Supreme Court has consistently[12] held that the Legislature may not impose a monetary cap on non- economic damages unless it provides a commensurate benefit, or it shows:

- An overpowering public necessity for the abolishment of the right to such damages exists; and
- There is no alternative method of meeting the public necessity.

B. RULE-MAKING AUTHORITY:

The bill provides the necessary rule making authority to carry out the provisions in the act.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

[12] *Smith v. Department of Insurance*, 507 So. D2 1080 (Fla. 1987), *Kuger v. White*, 281 So.2d 1 (Fla. 1973)

A bill to be entitled

An act relating to medical malpractice insurance; providing a short title; creating the Patient Safety and Provider Liability Act; providing legislative findings; creating s. 627.41485, F.S.; authorizing insurers to issue insurance coverage that excludes medical negligence for certain health care professionals within a hospital; authorizing the Department of Financial Services to adopt rules; amending s. 766.110, F.S.; specifying certain authorized insurers who may make available liability insurance; amending s. 766.118, F.S.; providing a limitation on noneconomic damages for a hospital facility that complies with certain patient-safety measures; creating s. 766.401, F.S.; providing definitions; creating s. 766.402, F.S.; authorizing an eligible hospital to petition the agency for an order certifying the hospital as a certified patient-safety facility; providing requirements for certification as a patient-safety facility; authorizing the agency to conduct onsite examinations; providing for revocation of an order certifying approval of a certified patient-safety facility; providing that an order certifying the approval of a certified patient-safety facility is conclusive evidence of compliance with statutory patient-safety requirements; providing that evidence of noncompliance is not admissible for any action for medical malpractice; creating s. 766.403, F.S.; providing requirements for a hospital to demonstrate that it is engaged in a common

enterprise for the care and treatment of patients; specifying required patient-safety measures; prohibiting a report or document generated under the act from being admissible or discoverable as evidence; creating s. 766.404, F.S.; requiring a certified patient-safety facility to submit an annual report to the agency and the Legislature; providing requirements for the annual report; providing that the annual report may include certain information from the Office of Insurance Regulation within the Department of Financial Services; providing that the annual report is subject to public-records requirements but is not admissible as evidence in a legal proceeding; creating s. 766.405, F.S.; providing for limitations on damages for eligible hospitals that are certified for compliance with certain patient-safety measures; creating s. 766.406, F.S.; providing rulemaking authority; providing for severability; providing for broad statutory view of the act; providing for self-execution of the act; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Short title.--This act may be cited as the "Patient Safety and Provider Liability Act."

Section 2. Legislative findings.--The Legislature finds that:

(1) This state is in the midst of a prolonged medical malpractice insurance crisis that has serious adverse effects on

patients, practitioners, licensed health care facilities, and all residents of this state.

(2) Hospitals are central components of the modern health care delivery system.

(3) The medical malpractice insurance crisis in this state can be alleviated by the adoption of innovative approaches for patient safety in teaching hospitals, which can lead to a reduction in medical errors coupled with a limitation on noneconomic damages that can be awarded against a teaching hospital that implements such innovative approaches.

(4) Statutory incentives are necessary to facilitate innovative approaches for patient safety in hospitals and that such incentives and patient-safety measures will benefit all persons seeking health care services in this state.

(5) Coupling patient safety measures and a limitation on provider liability in teaching hospitals will lead to a reduction in the frequency and severity of incidents of medical malpractice in hospitals.

(6) A reduction in the frequency and severity of incidents of medical malpractice in hospitals will reduce attorney's fees and other expenses inherent in the medical liability system.

(7) There is no alternative method that addresses the overwhelming public necessity to implement patient-safety measures and limit provider liability.

(8) Making high-quality health care available to the residents of this state is an overwhelming public necessity.

(9) Medical education in this state is an overwhelming public necessity.

(10) Statutory teaching hospitals are essential for high-quality medical care and medical education in this state.

(11) The critical mission of statutory teaching hospitals is severely undermined by the ongoing medical malpractice crisis.

(12) Teaching hospitals are appropriate health care facilities for the implementation of innovative approaches to enhancing patient safety and limiting provider liability.

(13) There is an overwhelming public necessity to impose reasonable limitations on actions for medical malpractice against teaching hospitals in furtherance of the critical public interest in promoting access to high-quality medical care, medical education, and innovative approaches to patient safety and provider liability.

(14) There is an overwhelming public necessity for teaching hospitals to implement innovative measures for patient safety and limit provider liability in order to generate empirical data for state policymakers concerning the effectiveness of these measures. Such data may lead to broader application of these measures in a wider array of hospitals after a reasonable period of evaluation and review.

(15) There is an overwhelming public necessity to promote the academic mission of teaching hospitals. Furthermore, the Legislature finds that the academic mission of these medical facilities is materially enhanced by statutory authority for the implementation of innovative approaches to promoting patient safety and limiting provider liability. Such approaches can be carefully studied and learned by medical students, medical

school faculty, and affiliated physicians in appropriate clinical settings, thereby enlarging the body of knowledge concerning patient safety and provider liability which is essential for advancement of patient safety, reduction of expenses inherent in the medical liability system, and curtailment of the medical malpractice insurance crisis in this state.

Section 3. Section 627.41485, Florida Statutes, is created to read:

627.41485 Medical malpractice insurers; optional coverage exclusion for insureds that maintain a patient-safety plan specified in s. 766.403.--

(1) An insurer issuing policies of professional liability coverage for claims arising out of the rendering of, or the failure to render, medical care or services may make available to physicians licensed under chapter 458, osteopathic physicians licensed under chapter 459, podiatric physicians licensed under chapter 461, dentists licensed under chapter 466, and nurses licensed under part I of chapter 464 coverage having an appropriate exclusion for acts of medical negligence occurring within the premises of a hospital that has agreed to indemnify covered persons for legal liability pursuant to s. 766.110(2), subject to the usual underwriting standards.

(2) The Department of Financial Services may adopt rules pursuant to ss. 120.536(1) and 120.54 to administer this section.

Section 4. Subsection (2) of section 766.110, Florida Statutes, is amended to read:

766.110 Liability of health care facilities.--

(2) Every hospital licensed under chapter 395 may carry liability insurance or adequately insure itself in an amount of not less than $1.5 million per claim, $5 million annual aggregate to cover all medical injuries to patients resulting from negligent acts or omissions on the part of those members of its medical staff who are covered thereby in furtherance of the requirements of ss. 458.320 and 459.0085. Notwithstanding s. 626.901, a licensed hospital and verified trauma center may extend insurance and self-insurance coverage to members of the medical staff, including physicians' practices, individually or through a professional association, as defined in chapter 621, and other health care practitioners, as defined in s. 456.001(4), including students preparing for licensure. Such coverage may be limited to legal liability arising out of medical negligence within the hospital premises as defined under s. 766.401. ~~Self-insurance~~ Coverage extended hereunder to a member of a hospital's medical staff meets the financial responsibility requirements of ss. 458.320 and 459.0085 if the physician's coverage limits are not less than the minimum limits established in ss. 458.320 and 459.0085 ~~and the hospital is a verified trauma center that has extended self-insurance coverage continuously to members of its medical staff for activities both inside and outside of the hospital~~. Any authorized insurer as defined in s. 626.914(2), risk retention group as defined in s. 627.942, or joint underwriting association established under s. 627.351(4) which is authorized to write casualty insurance may make available, but is ~~shall~~ not ~~be~~ required to write, such

coverage. The hospital may assess on an equitable and pro rata basis the following individuals to whom it extends coverage pursuant to this section ~~professional health care providers~~ for a portion of the total hospital insurance cost for this coverage: physicians licensed under chapter 458, osteopathic physicians licensed under chapter 459, podiatric physicians licensed under chapter 461, dentists licensed under chapter 466, ~~and~~ nurses licensed under part I of chapter 464, and other health professionals. The hospital may provide for a deductible amount to be applied against any individual health care provider found liable in a law suit in tort or for breach of contract. The legislative intent in providing for the deductible to be applied to individual health care providers found negligent or in breach of contract is to instill in each individual health care provider the incentive to avoid the risk of injury to the fullest extent and ensure that the citizens of this state receive the highest quality health care obtainable.

Section 5. Present subsections (6) and (7) of section 766.118, Florida Statutes, are renumbered as subsections (7) and (8), respectively, and a new subsection (6) is added to that section, to read:

766.118 Determination of noneconomic damages.--

(6) LIMITATION ON NONECONOMIC DAMAGES FOR NEGLIGENCE OF CERTAIN HOSPITALS.--With respect to a complaint for personal injury or wrongful death arising from medical negligence, a hospital that has received an order from the Agency for Health Care Administration pursuant to s. 766.402 which certifies that the facility complies with patient-safety measures specified in

s. 766.403 shall be liable for no more than $500,000 in noneconomic damages, regardless of the number of claimants, number of claims, or theory of liability, including vicarious liability, arising from the same nucleus of operative fact, notwithstanding any other provision of this section.

Section 6. Section 766.401, Florida Statutes, is created to read:

766.401 Definitions.--As used in this section and ss. 766.402-766.405, the term:

(1) "Affected patient" means a patient of a certified patient-safety facility.

(2) "Affected practitioner" means any person, including a physician, who is credentialed by the eligible hospital to provide health care services in a certified patient-safety facility.

(3) "Agency" means the Agency for Health Care Administration.

(4) "Certified patient-safety facility" means any eligible hospital that, in accordance with an order from the Agency for Health Care Administration, has adopted a patient-safety plan.

(5) "Clinical privileges" means the privileges granted to a physician or other licensed health care practitioner to render patient-care services in a hospital.

(6) "Eligible hospital" or "licensed facility" means a statutory teaching hospital, as defined by s. 408.07, which maintains at least seven different accredited programs in graduate medical education and has 100 or more full-time equivalent resident physicians.

(7) "Health care provider" or "provider" means:

(a) An eligible hospital.

(b) A physician or a physician assistant licensed under chapter 458.

(c) An osteopathic physician or an osteopathic physician assistant licensed under chapter 459.

(d) A registered nurse, nurse midwife, licensed practical nurse, or advanced registered nurse practitioner licensed or registered under part I of chapter 464 or any facility that employs nurses licensed or registered under part I of chapter 464 to supply all or part of the care delivered by that facility.

(e) A health care professional association and its employees or a corporate medical group and its employees.

(f) Any other medical facility in which the primary purpose is to deliver human medical diagnostic services or to deliver nonsurgical human medical treatment, including an office maintained by a provider.

(g) A free clinic that delivers only medical diagnostic services or nonsurgical medical treatment free of charge to low-income persons not otherwise covered by Medicaid or other programs for low-income persons.

(h) Any other health care professional, practitioner, or provider, including a student enrolled in an accredited program, who prepares the student for licensure as any one of the professionals listed in this subsection.

(i) Any person, organization, or entity that is vicariously liable under the theory of respondeat superior or

any other theory of legal liability for medical negligence committed by any licensed professional listed in this subsection.

(j) Any nonprofit corporation qualified as exempt from federal income taxation under s. 501(a) of the Internal Revenue Code and described in s. 501(c) of the Internal Revenue Code, including any university or medical school that employs licensed professionals listed in this subsection or which delivers health care services provided by licensed professionals listed in this subsection, any federally funded community health center, and any volunteer corporation or volunteer health care provider that delivers health care services.

(8) "Health care practitioner" or "practitioner" means any person, entity, or organization identified in subsection (7), except for a hospital.

(9) "Medical incident" or "adverse incident" has the same meaning as provided in ss. 381.0271, 395.0197, 458.351, and 459.026.

(10) "Medical negligence" means medical malpractice, whether grounded in tort or in contract, arising out of the rendering of or failure to render medical care or services.

(11) "Person" means any individual, partnership, corporation, association, or governmental unit.

(12) "Premises" means those buildings, beds, and equipment located at the address of the licensed facility and all other buildings, beds, and equipment for the provision of the hospital, ambulatory surgical, mobile surgical care, primary care, or comprehensive health care under the dominion and

control of the licensee, including offices and locations where the licensed facility offers medical care and treatment to affected patients.

(13) "Statutory teaching hospital" or "teaching hospital" has the same meaning as provided in s. 408.07.

Section 7. Section 766.402, Florida Statutes, is created to read:

766.402 Agency approval of patient-safety plans.--

(1) An eligible hospital that has adopted a patient-safety plan may petition the agency to enter an order certifying approval of the hospital as a certified patient-safety facility.

(2) In accordance with chapter 120, the agency shall enter an order certifying approval of the certified patient-safety facility upon a showing that, in furtherance of an approach to patient safety:

(a) The petitioner has established safety measures for the care and treatment of patients.

(b) The petitioner satisfies requirements for patient-protection measures, as specified in s. 766.403.

(c) The petitioner satisfies all other requirements of ss. 766.401-766.405.

(3) Upon entry of an order approving the petition, the agency may conduct onsite examinations of the licensed facility to ensure continued compliance with the terms and conditions of the order.

(4) The order approving a petition under this section remains in effect until revoked. The agency may revoke the order upon reasonable notice to the eligible hospital that it fails to

comply with material requirements of s. 766.403 and that the hospital has failed to cure stated deficiencies upon reasonable notice. Revocation of an agency order pursuant to s. 766.403 applies prospectively to any cause of action for medical negligence which arises on or after the effective date of the order of revocation.

(5) An order approving a petition under this section is, as a matter of law, conclusive evidence that the hospital complies with the applicable patient-safety requirements of s. 766.403. A hospital's noncompliance with the requirements of s. 766.403 does not affect the limitations on damages conferred by this section. Evidence of noncompliance with s. 766.403 is not admissible for any purpose in any action for medical malpractice. This section, or any portion thereof, may not give rise to an independent cause of action for damages against any hospital.

Section 8. Section 766.403, Florida Statutes, is created to read:

766.403 Patient-safety plans.--

(1) In order to satisfy the requirements of s. 766.402, the licensed facility shall have a patient-safety plan, which provides that the facility shall:

(a) Have in place a process, either through the facility's patient-safety committee or a similar body, for coordinating the quality control, risk management, and patient-relations functions of the facility and for reporting to the facility's governing board at least quarterly regarding such efforts.

(b) Establish within the facility a system for reporting

near misses and agree to submit any information collected to the Florida Patient Safety Corporation. Such information must be submitted by the facility and made available by the Patient Safety Corporation in accordance with s. 381.0271(7).

(c) Design and make available to facility staff, including medical staff, a patient-safety curriculum that provides lecture and web-based training on recognized patient-safety principles, which may include training in communication skills, team-performance assessment and training, risk-prevention strategies, and best practices and evidence-based medicine. The licensed facility shall report annually the programs presented to the agency.

(d) Implement a program to identify health care providers on the facility's staff who may be eligible for an early-intervention program that provides additional skills assessment and training and offer such training to the staff on a voluntary and confidential basis with established mechanisms to assess program performance and results.

(e) Implement a simulation-based program for skills assessment, training, and retraining of a facility's staff in those tasks and activities that the agency identifies by rule.

(f) Designate a patient advocate who coordinates with members of the medical staff and the facility's chief medical officer regarding the disclosure of adverse medical incidents to patients. In addition, the patient advocate shall establish an advisory panel, consisting of providers, patients or their families, and other health care consumers or consumer groups to review general patient-safety concerns and other issues related

to relations among and between patients and providers and to identify areas where additional education and program development may be appropriate.

(g) Establish a procedure to biennially review the facility's patient-safety program and its compliance with the requirements of this section. Such review shall be conducted by an independent patient-safety organization as defined in s. 766.1016(1) or other professional organization approved by the agency. The organization performing the review shall prepare a written report that contains detailed findings and recommendations. The report shall be forwarded to the facility's risk manager or patient-safety officer, who may make written comments in response. The report and any written comments shall be presented to the governing board of the licensed facility. A copy of the report and any of the facility's responses to the findings and recommendations shall be provided to the agency within 60 days after the date that the governing board reviewed the report. The report is confidential and exempt from production or discovery in any civil action. Likewise, the report and the information contained therein are not admissible as evidence for any purpose in any action for medical negligence.

(h) Establish a system for the trending and tracking of quality and patient-safety indicators that the agency may identify by rule and a method for review of the data at least semiannually by the facility's patient-safety committee.

(2) This section does not constitute an applicable standard of care in any action for medical negligence or

otherwise create a private right of action, and evidence of noncompliance with this section is not admissible for any purpose in any action for medical negligence against any health care provider.

(3) This section does not prohibit the licensed facility from implementing other measures for promoting patient safety within the premises. This section does not relieve the licensed facility from the duty to implement any other patient-safety measure that is required by state law. The Legislature intends that the patient-safety measures specified in this section are in addition to all other patient-safety measures required by state law, federal law, and applicable accreditation standards for licensed facilities.

(4) A review, report, or other document created, produced, delivered, or discussed pursuant to this section is not discoverable or admissible as evidence in any legal action.

Section 9. Section 766.404, Florida Statutes, is created to read:

766.404 Annual report.--

(1) Each certified patient-safety facility shall submit an annual report to the agency containing information and data reasonably required by the agency to evaluate performance and effectiveness of its patient-safety plan. However, information may not be submitted or disclosed in violation of any patient's right to privacy under state or federal law.

(2) The agency shall aggregate information and data submitted by all certified patient-safety facilities, and each year, on or before March 1, the agency shall submit a report to

the President of the Senate and the Speaker of the House of Representatives which evaluates the performance and effectiveness of the approach to enhancing patient safety and limiting provider liability in certified patient-safety facilities. The report must include, but need not be limited to, pertinent data concerning:

(a) The number and names of certified patient-safety facilities;

(b) The number and types of patient-protection measures currently in effect in these facilities;

(c) The number of affected patients;

(d) The number of surgical procedures on affected patients;

(e) The number of medical incidents, claims of medical malpractice, and claims resulting in indemnity;

(f) The average time for resolution of contested and uncontested claims of medical malpractice;

(g) The percentage of claims which result in civil trials;

(h) The percentage of civil trials which result in adverse judgments against affected facilities;

(i) The number and average size of an indemnity paid to claimants;

(j) The estimated liability expense, inclusive of medical liability insurance premiums; and

(k) The percentage of medical liability expense, inclusive of medical liability insurance premiums, which is borne by affected practitioners in certified patient-safety facilities.

The report may also include other information and data that the agency deems appropriate to gauge the cost and benefit of patient-safety plans.

(3) The agency's annual report to the President of the Senate and the Speaker of the House of Representatives may include relevant information and data obtained from the Office of Insurance Regulation within the Department of Financial Services concerning the availability and affordability of enterprise-wide medical liability insurance coverage for affected facilities and the availability and affordability of insurance policies for individual practitioners which contain coverage exclusions for acts of medical negligence in facilities that indemnify health practitioners. The Office of Insurance Regulation shall cooperate with the agency in the reporting of information and data specified in this subsection.

(4) Reports submitted to the agency by certified patient-safety facilities pursuant to this section are public records under chapter 119. However, these reports, and the information contained therein, are not admissible as evidence in a court of law in any action.

Section 10. Section 766.405, Florida Statutes, is created to read:

766.405 Damages in malpractice actions against certain hospitals that meet patient-safety requirements; agency approval of patient-safety measures.--

(1) In recognition of their essential role in training future health care providers and in providing innovative medical care for this state's residents, in recognition of their

commitment to treating indigent patients, and further in recognition that teaching hospitals, as defined in s. 408.07, provide benefits to the residents of this state through their roles in improving the quality of medical care, training of health care providers, and caring for indigent patients, the limits of liability for medical malpractice arising out of the rendering of, or the failure to render, medical care by all such hospitals shall be determined in accordance with the requirements of this section.

(2) Upon entry of an order and for the entire period of time that the order remains in effect, the damages recoverable from an eligible hospital covered by the order and from its employees and agents in actions arising from medical negligence shall be determined in accordance with the following provisions:

(a) Noneconomic damages shall be limited to a maximum of $500,000, regardless of the number of claimants, number of claims, or the theory of liability pursuant to s. 766.118(6).

(b) Awards of economic damages shall be offset by payments from collateral sources, as defined by s. 766.202(2), and any set-offs available under ss. 46.015 and 768.041. Awards for future economic losses shall be offset by future collateral source payments.

(c) After being offset by collateral sources, awards of future economic damages shall, at the option of the eligible hospital, be reduced by the court to present value or paid through periodic payments in the form of an annuity or a reversionary trust. A company that underwrites an annuity to pay future economic damages shall have a rating of "A" or higher by

A.M. Best Company. The terms of the reversionary instrument used to periodically pay future economic damages must be approved by the court. Such approval may not be unreasonably withheld.

(3) The limitations on damages in subsection (2) apply prospectively to causes of action for medical negligence which arise on or after the effective date of the order.

Section 11. Section 766.406, Florida Statutes, is created to read:

766.406 Rulemaking authority.--The agency may adopt rules pursuant to ss. 120.536(1) and 120.54 to administer ss. 766.401-766.405.

Section 12. If any provision of this act or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end, the provisions of this act are severable.

Section 13. If a conflict exists between any provision of this act and s. 456.052, s. 456.053, s. 456.054, s. 458.331, s. 459.015, or s. 817.505, Florida Statutes, the provisions of this act shall govern. The provisions of this act shall be broadly construed in furtherance of the overriding legislative intent to facilitate innovative approaches for enhancing patient protection and limiting provider liability in eligible hospitals.

Section 14. It is the intention of the Legislature that the provisions of this act are self-executing.

Section 15. This act shall take effect upon becoming a

law.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1409 Florida Health Information Network, Inc.
SPONSOR(S): Benson
TIED BILLS: HB 1411 **IDEN./SIM. BILLS:** SB 2786

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee		Bell ASB	Mitchell
2) Health Care Appropriations Committee			
3) Health & Families Council			
4)			
5)			

SUMMARY ANALYSIS

HB 1409 creates the "Florida Health Information Network Act" as a public/private partnership that will implement a statewide electronic medical records network.

The bill establishes the Florida Health Information Network, Inc., as a not-for-profit corporation. The corporation will be managed by an uncompensated board of directors. The initial board will consist of the current Governor's Health Information Infrastructure Advisory Board (for 18 months).

The primary duties of the Florida Health Information Network, Inc. are to oversee, coordinate, and implement a statewide electronic medical records network. Among the many duties listed in the enabling legislation, the Florida Health Information Network, Inc. is charged with development of technical standards for electronic medical records and recruiting participants into the network.

The Agency for Health Care Administration (AHCA) will provide oversight of the Florida Health Information Network, Inc.

The bill appropriates $9,426,117 from the General Revenue Fund to AHCA to carry out the Florida Health Information Network Act.

The effective date of the bill is July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government – The bill creates the Florida Health Information Network, Inc. as a not for profit corporation. The fiscal impact of the bill is $9,426,117.

Empower Families/Safeguard Individual Liberty – Full implementation of electronic medical records may increase individual's access to their own health care information, provide more transparency in the health care system, and increase the quality of care.

Maintain Public Security – Full implementation of electronic medical records would better prepare the state for natural or manmade disasters, such as hurricanes.

B. EFFECT OF PROPOSED CHANGES:

HB 1409 creates s. 408.064, F.S., to establish the "Florida Health Information Network Act" to promote statewide integration of electronic medical records. It creates the Florida Health Information Network, Inc., as a not-for-profit corporation. That will be managed by an uncompensated board of directors. The initial board will consist of the current Governor's Health Information Infrastructure Advisory Board (for 18 months).

The primary duty of the Florida Health Information Network, Inc. is to develop a statewide health information network. To accomplish this end the Florida Health Information Network, Inc. is directed in its enabling legislation to:

- Devise and implement a strategic plan for infrastructure development, and periodically evaluate and modify the plan;
- Develop, operate, and maintain the technical infrastructure necessary to perform the functions of the network consistent with the strategic plan;
- Promote an integrated approach to efforts to create a secure network for communication of electronic health information in the state;
- Market the network to promote widespread use;
- Assist in the development and expansion of existing local or regional health information networks and the creation of new networks;
- Develop annual budgets;
- Take commercially reasonable measures to protect its intellectual property, including obtaining patents, trademarks, and copyrights where appropriate; and
- Make recommendations for reform of the state's laws regarding medical records.

The Florida Health Information Network, Inc. is also charged with developing and enforcing privacy, security, operational, and technical standards among regional and local health information networks.

The bill requires the Florida Health Information Network, Inc. to regularly assess the adoption of electronic records systems and utilization of the statewide network and incorporate the results into its regular strategic planning process.

The Agency for Heath Care Administration (AHCA) is responsible for promoting the development of the health information network as a public-private partnership in the state. AHCA is responsible for developing and implementing a plan for the formation and operation of the health information network.

Pursuant to HB 1409, AHCA will contract with the Florida Health Information Network, Inc. to implement the plan, July 1, 2006, through June 30, 2008.

The effective date of the bill is July 1, 2006.

CURRENT SITUATION

Florida Health Information Network

In June 2005, President Bush called for most Americans to have electronic health records[1] within ten years. Florida is currently working towards this end. Existing section 408.062(5), F.S., requires the Agency for Health Care Administration (AHCA) to develop a strategic plan for the adoption and use of electronic health records. AHCA is authorized to develop rules to facilitate the functionality and protect the confidentiality of electronic health records.

AHCA provides staff support to the Governor's Health Information Infrastructure Advisory Board which was established by Executive Order 04-93 in May of 2004. The Advisory Board advises and supports AHCA as it develops and implements a strategy for the adoption and use of electronic health records and creates a plan to promote the development and implementation of a Florida health information infrastructure. Under current law, the Board may continue to operate until June of 2007.

AHCA received $1.5 million in fiscal year 2005-2006 for the Florida health information network to be used to provide grant funding of local and regional health information exchange pilot projects.

BACKGROUND

Paper-based records have been in existence for centuries and their gradual replacement by computer-based records has been slowly underway for over twenty years. Computerized information systems have not achieved the same degree of penetration in healthcare as that seen in other sectors such as finance, transport and the manufacturing and retail industries. Further, deployment has varied greatly from area to area and from specialty to specialty and in many cases has revolved around local systems designed for local use. National penetration of electronic medical records may have reached over 90% in primary care practices in Norway, Sweden and Denmark (2003), but has been limited to only 17% of physician office practices in the USA (2001-2003).[2] According to AHCA, only 20% of Florida physicians are using electronic health records.

C. SECTION DIRECTORY:

Section 1. – Creates s. 408.064, F.S., to the Florida Health Information Network, Inc. as a not-for-profit corporation.

Section 2. – Provides an appropriation of $9,426,117, F.S., from General Revenue, for purposes of creating the Florida Health Information Network, Inc.

Section 3. – Provides that the bill will take effect July 1, 2006.

[1] According to the Florida Senate Interim Project 2006-135, "An electronic health record is a digital collection of information from a patient's medical history that may include diagnoses, prescribed medications, vital signs, immunizations, and personal characteristics."
[2] Health and Human Services, 2005.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill appropriates $9,426,117 from the General Revenue Fund to the Agency for Health Care Administration for the 2006-2007 fiscal year.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

The long-term impacts of electronic medical records are estimated to create more efficiency in the health care system and improve patient safety. Researchers estimate that nationwide implementation of electronic medical records could eventually save more than $81 billion annually.[3]

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds. This bill does not reduce the percentage of state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The Agency for Health Care Administration has the necessary rulemaking authority to carry out the provisions in the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

[3] Health Affairs, 24, no. 5 (2005): 1103-1117.

A bill to be entitled

An act relating to the Florida Health Information Network, Inc.; creating s. 408.064, F.S.; providing a short title and purpose; requiring the Agency for Health Care Administration to develop and implement a plan for the formation and operation of a health information network; requiring the agency to enter into a contract to implement the plan; creating the Florida Health Information Network, Inc., as a not-for-profit corporation; providing for a board of directors and for terms thereof; providing duties and responsibilities of the corporation; requiring a report to the Governor and Legislature; providing an appropriation; providing an effective date.

WHEREAS, the cost of health care in Florida has grown substantially while the demand for a more coordinated system of health care has increased, and

WHEREAS, with the benefit of an effective system for sharing privacy-protected medical information among authorized health care stakeholders, health care providers and consumers, aided by computerized tools that automatically analyze available health information and by combining that data with clinical logic and practice guidelines based on current, sound medical science, will have access to the medical information needed to make sound decisions about health care, and

WHEREAS, the state's health care system would benefit from a reduction in the time it takes to evaluate promising medical techniques, devices, and drugs and to bring the products and

procedures that are proven safe and effective to the health care marketplace more quickly, and

WHEREAS, the state's public health officers require effective information systems to detect, monitor, and manage emerging health threats most efficiently, and

WHEREAS, a successful medical response to large-scale disasters such as hurricanes is enhanced by effective and timely access to the medical records of those needing medical care, and

WHEREAS, providing consumers with effective access to their personal health information and computerized tools that gather data from their medical records and assist in interpreting and monitoring the data in partnership with their health care providers would permit consumers to become better informed and more proactive in managing their health and wellness, thereby reducing utilization of and adding efficiencies to the health care system, and

WHEREAS, it is feasible and advisable for the state to implement an effective integrated health information network capable of drawing together critical health information from multiple sources and presenting that information to authorized parties in a usable format to support sound decisions about health care by providers, consumers, public health officers, and researchers while ensuring the privacy and security of personal health information, and

WHEREAS, studies have shown that health information networks are more likely to succeed if they are developed, implemented, and operated by a neutral manager with broad support among health care stakeholders, and

WHEREAS, the Legislature declares that an integrated health information network is a necessary and important part of effectively addressing the challenges and opportunities facing the state's health care delivery system, and it is the policy of the state to promote the development and implementation of an integrated statewide health information network to be operated by a neutral manager as a public-private partnership, with reasonable oversight and regulation by the state to promote the safety, security, and integrity of the health information network, NOW, THEREFORE,

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 408.064, Florida Statutes, is created to read:

408.064 Florida Health Information Network Act; purpose; duties.--

(1) This section may be cited as the "Florida Health Information Network Act."

(2) The purpose of this section is to promote the establishment of a privacy-protected and secure integrated statewide network for the communication of electronic health information among authorized parties and to foster a coordinated public-private initiative for the development and operation of Florida's health information infrastructure.

(3) The agency is responsible for promoting the development of a health information network as a public-private partnership among the state's providers, payors, consumers,

employers, public health officials, medical researchers, and other health care stakeholders. The agency shall develop and implement a plan for the formation and operation of a health information network and shall contract with the Florida Health Information Network, Inc., for the purpose of implementing the plan, in conformity with the legislative intent expressed in this section, for the period July 1, 2006, through June 30, 2008.

(4) There is created a not-for-profit corporation, to be known as the "Florida Health Information Network, Inc.," which shall be registered, incorporated, organized, and operated in compliance with chapter 617, and which shall not be a unit or agency of state government. The affairs of the not-for-profit corporation shall be managed by a board of directors who shall serve without compensation. The initial board of directors shall be the Governor's Health Information Infrastructure Advisory Board which shall serve a term of 18 months. Upon expiration of the terms of the initial members, members shall be appointed to 4-year staggered terms in accordance with s. 20.052 by majority vote as provided in the bylaws of the corporation. Any vacancy in office shall be filled for the remainder of the term by majority vote of the members. Any member may be reappointed.

(5) The Florida Health Information Network, Inc., shall:

(a) Institute a statewide health information network in the state by:

1. Devising and implementing a strategic plan for infrastructure development and periodically evaluating and modifying that plan.

2. Developing, operating, and maintaining the technical infrastructure necessary to perform the functions of the network consistent with the strategic plan.

3. Promoting an integrated approach to efforts to create a secure network for communication of electronic health information in the state.

4. Marketing the network to promote widespread use of the network.

5. Assisting in the development and expansion of existing local or regional health information networks and the creation of new networks.

(b) Develop and implement specific programs or strategies that address the creation, development, and expansion of regional or local health information networks and the recruitment of participants in the network.

(c) Specify standards among regional and local health information networks and other participants in the Florida Health Information Network, Inc., to promote effective statewide and interstate interoperability.

(d) Regularly assess the adoption of electronic health records systems and utilization of the statewide network by providers, consumers, public health officers, and other health care stakeholders to identify and regularly reevaluate the state's health information infrastructure strengths and weaknesses, assess opportunities to increase consumer access to the consumer's health records, and incorporate such information into its regular strategic planning process.

(e) Develop and enforce privacy, security, operational, and technical standards among regional and local health information networks to ensure effective statewide privacy, data security, efficiency, and interoperability across the network. The network's standards shall be guided by reference to widely adopted standards or standards accepted by recognized national standard-setting organizations.

(f) Develop annual budgets that include funding from public and private entities, including user fees.

(g) Take commercially reasonable measures to protect its intellectual property, including obtaining patents, trademarks, and copyrights where appropriate.

(h) Make recommendations for reform of the state's laws regarding medical records.

(6) The agency shall review the data gathered about the Florida Health Information Network, Inc., pursuant to paragraph (5)(d) and make recommendations for its continued development in a report to be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives by June 1, 2007.

Section 2. The sum of $9,426,117 is appropriated from the General Revenue Fund to the Agency for Health Care Administration for the 2006-2007 fiscal year to carry out the purposes of this act.

Section 3. This act shall take effect July 1, 2006.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1411 Public Records
SPONSOR(S): Benson
TIED BILLS: HB 1409 **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee		Bell AJB	Mitchell
2) Governmental Operations Committee			
3) Health & Families Council			
4)			
5)			

SUMMARY ANALYSIS

HB 1411 creates s. 408.0641, F.S., to provide a public records exemption for certain information held by the Florida Health Information Network, Inc established in HB 1409. The exempt information is:

- A patient's medical or health record;
- Trade secrets as defined in s. 688.002, F.S.; and
- Any information received from a person from another state or nation or the Federal Government which is otherwise confidential or exempt pursuant to the laws of that state or nation or pursuant to federal law.

HB 1411 is linked to HB 1409. HB 1409 creates the "Florida Health Information Network Act" as a nexus towards a public/private partnership that will implement a statewide electronic medical records network.

The bill provides for future review and repeal of the exemption on October 2, 2011, provides a statement of public necessity, and provides a contingent effective date.

The bill requires a two-thirds vote of the members present and voting for passage.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government – The bill limits access to public records.

Safeguard Individual Liberty – The bill provides that patient medical record or health records held by the Florida Health Information Network are private.

B. EFFECT OF PROPOSED CHANGES:

HB 1411 creates s. 408.0641, F.S., to provide a public records exemption for certain information held by the Florida Health Information Network Inc. The exempt information is:

- A patient's medical or health record;
- Trade secrets as defined in s. 688.002, F.S.; and
- Any information received from a person from another state or nation or the Federal Government which is otherwise confidential or exempt pursuant to the laws of that state or nation or pursuant to federal law.

The bill provides for future review and repeal of the exemption on October 2, 2011, pursuant to the Open Government Sunset Review Act of 1995. It also provides a statement of public necessity and provides an effective date.

HB 1409

HB 1409 creates the Florida Health Information Network Act as a public/private partnership that will implement a statewide electronic medical records network. It establishes the Florida Health Information Network, Inc., as a not-for-profit corporation. That will be managed by an uncompensated board of directors. The initial board will consist of the current Governor's Health Information Infrastructure Advisory Board (for 18 months).

The primary duties of the Florida Health Information Network, Inc. are to oversee, coordinate, and implement a statewide electronic medical records network. Among the many duties listed in the enabling legislation, the Florida Health Information Network is charged with development of technical standards for electronic medical records and recruiting participants into the network.

The Agency for Health Care Administration (AHCA) will provide oversight on the Florida Health Information Network, Inc.

C. SECTION DIRECTORY:

Section 1. – Creates s. 408.0641, F.S., to create a public records exemption for a patient's medical records, trade secrets, and any other information that is confidential under state or federal law that are held by the Florida Health Information Network.

Section 2. – Provides a statement of public necessity.

Section 3. – Provides a contingent effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds. This bill does not reduce the percentage of state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

   Article I, s. 24(c) of the Florida Constitution, requires a two-thirds vote of the members present and voting for passage of a newly created public records or public meetings exemption. Thus, the bill requires a two-thirds vote for passage.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Public Records and Public Meetings Laws

Article I, s. 24(a), Florida Constitution, sets forth the state's public policy regarding access to government records. The section guarantees every person a right to inspect or copy any public record of the legislative, executive, and judicial branches of government. Article I, s. 24(b), Florida Constitution, sets forth the state's public policy regarding access to government meetings. The section requires all meetings of the executive branch and local government be open and noticed to the public.

The Legislature may, however, provide by general law for the exemption of records and meetings from the requirements of Article I, s. 24, Florida Constitution. The general law must state with specificity the public necessity justifying the exemption (public necessity statement) and must be no broader than necessary to accomplish its purpose.

Public policy regarding access to government records and meetings is also addressed in the Florida Statutes. Section 119.07(1), F.S., also guarantees every person a right to inspect, examine, and copy any state, county, or municipal record, and s. 286.011, F.S., requires that all state, county, or municipal meetings be open and noticed to the public. Furthermore, the Open Government Sunset Review Act of 1995[1] provides that a public records or public meetings exemption may be created or maintained only if it serves an identifiable public purpose, and may be no broader than is necessary to meet one of the following public purposes:

- Allowing the state or its political subdivisions to effectively and efficiently administer a governmental program, which administration would be significantly impaired without the exemption;
- Protecting sensitive personal information that, if released, would be defamatory or would jeopardize an individual's safety. However, only the identity of an individual may be exempted under this provision; or,
- Protecting trade or business secrets.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

[1] Section 119.15, F.S.

A bill to be entitled

An act relating to public records; creating s. 408.0641, F.S.; providing an exemption from public records requirements for patient medical or health records, trade secrets, and certain other information that is confidential or exempt contained in records of the Florida Health Information Network, Inc.; providing for review and repeal; providing a statement of public necessity; providing a contingent effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 408.0641, Florida Statutes, is created to read:

408.0641 Florida Health Information Network, Inc.; public records exemption.--

(1) The following information held by the Florida Health Information Network, Inc., is confidential and exempt from of s. 119.07(1) and s. 24, Art. I of the State Constitution:

(a) A patient's medical or health record.

(b) Trade secrets as defined in s. 688.002.

(c) Any information received from a person from another state or nation or the Federal Government which is otherwise confidential or exempt pursuant to the laws of that state or nation or pursuant to federal law.

(2) This section is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed

on October 2, 2011, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2. The Legislature finds that it is a public necessity that a patient's medical or health record held by the Florida Health Information Network, Inc., a not-for-profit corporation, be made confidential and exempt from public records requirements. Matters of personal health are traditionally private and confidential concerns between the patient and the health care provider. The private and confidential nature of personal health matters pervades both the public and private health care sectors. For these reasons, the individual's expectation of and right to privacy in all matters regarding his or her personal health necessitates this exemption. The Legislature further finds that it is a public necessity to protect a patient's medical record or health record because the release of such record could be defamatory to the patient or could cause unwarranted damage to the name or reputation of that patient. The Legislature also finds that it is a public necessity to protect the release of a trade secret as defined in s. 688.002, Florida Statutes. A trade secret derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use. Without an exemption from public records requirements for a trade secret as defined in s. 688.002, Florida Statutes, that trade secret becomes a public record when held by the Florida Health Information Network, Inc., and must be divulged upon request. Divulgence of any trade secret under

the public records law would destroy the value of that property. Release of that information would give business competitors an unfair advantage and weaken the position of the corporation in the marketplace. Thus, the Legislature finds that it is a public necessity that a trade secret be made confidential and exempt from public records requirements. Finally, the Legislature finds that it is a public necessity to protect information received by the Florida Health Information Network, Inc., from a person from another state or nation or the Federal Government which is otherwise exempt or confidential pursuant to the laws of that state or nation or pursuant to federal law. Without this protection, another state or nation or the Federal Government might be less likely to provide information to the corporation in the furtherance of its duties and responsibilities.

Section 3. This act shall take effect July 1, 2006, if House Bill 1409 or similar legislation is adopted in the same legislative session or an extension thereof and becomes law.